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## A CLINICAL LECTURE.

*Delivered at the Pennsylvania Hospital,*

By JAMES H. HUTCHINSON, M. D., Physician to the Hospital.

### Graves' Disease.

*Gentlemen:* The first patient whom I shall show you is a colored woman, 47 years of age, who was admitted to the hospital November 17th, that is, four days ago. She was born in New Jersey, and has recently lived at Atlantic City. Her father died of senility at an advanced age, and her mother of consumption when the patient was ten years old. She has two brothers living and healthy. One brother died of hepatic disease, another of heart trouble and a third of some cause unknown to the patient. She has three sisters living and three dead. Two of these were still-born and the third died shortly after birth. She is by occupation a clothes washer. She began to menstruate at the age of fourteen, and was always regular, until the menopause, which occurred six months ago. She has been married twice, and has had eight children, four of whom are dead; one from a large abscess in the axilla, one from pneumonia, one was fatally burned, and the fourth died of consumption. She had two miscarriages shortly after marriage. Some years ago she had a slight attack of rheumatism. She has been subjected to no severe mental shock, although she grieved a great deal after the death of her first husband.

About the first of last January she was taken sick with a cough, accompanied with expectoration of a yellow sputum, pain in the back and limbs, swelling of the feet, and palpitation of the heart. It was then noticed that the eyeballs were prominent, These symptoms continued during the winter, but in the spring they partially subsided. The patient was, however, sick off and on during the summer, and unable to work. Since October 1st she has gradually grown worse; the limbs have become swollen, the heart acts violently, and attacks of palpitation are brought on by slight exertion. She also had paroxysmal attacks of coughing and has lost flesh rapidly. The bowels are costive, the appetite poor, and the eyeballs have again become prominent.

We shall now turn to the examination of the patient; but before doing so I will call attention to the temperature chart, which shows that there has been no fever since the patient has been in the hospital. The respirations are rather frequent and the pulse is very rapid. At the time of her entrance to the hospital the pulse was 128 and the respirations 46 a minute. Part of this increase may have been due to the exertion of coming here. Since then the pulse and respiration have decreased in frequency, but are still much above normal. Looking at the patient, you will at once see that the eyeballs are even more prominent than they usually are in the colored race, in which, I think, there is normally more prominence of the eyeballs than in the white race. The protrusion is not so great but that she can close the lids over the ball. When I examine the heart, I find a condition of things which, with the protrusion of the eyeballs, leads me to believe that this is a case of what is known as Graves' disease, or exophthalmic goitre. There is, however, in this case, an important symptom absent, but one which is not necessarily present in all cases; that is, enlargement of the thyroid body. Examining the region of the heart, I can see very clearly that there is increased action of the heart. Pulsation is visible in several of the interspaces, and is not merely confined to the fifth interspace, as in health. Placing my hand over the heart, I feel the impulse over the whole precordial region. There is then an increased area of impulse. Pulsation can be felt even to the right of the sternum. At the time that I first saw her there was, in addition to increased action of the heart and increased frequency of pulsation, irregularity in the cardiac action. Finding these symptoms, I at once examined the neck for enlargement of the thyroid body, but this is absent. The term exophthalmic goitre, which is often applied to this disease, is therefore, to a certain extent, a misnomer. I however found increased action of the vessels of the neck.

This, then, is a case of what is called Graves' disease. This name is given to it because Graves was the first to thoroughly describe it. It is also known as Basedow's disease. If we apply the name of any man to the affection, we should call it Graves' disease, for his description was five years anterior to that of Basedow. Certain of the symptoms were, however, described long before the appearance of Graves' paper. Dr. Parry described them early in this century, but, while he called attention to the enlargement of the thyroid body and the tumultuous action of the heart, he missed the prominence of the eyeballs. The symptoms were recognized even before this by a Roman physician, but the first thorough description was that of Graves. There are, of course, objections to giving the name of any person to a disease, but there is sometimes difficulty in doing otherwise. The term exophthalmic goitre is not a good one, for as I have told you, and as you see in this case, goitre may be absent. So, too, prominence of the eyeball may be wanting. The name "struma exophthalmica," as suggested by Virchow, is objectionable, because there is here no struma in the ordinary meaning of that term. I think that on the whole it is as well called Graves' disease as by any other name.

The essential part of this disease is unquestionably the tumultuous action of the heart. I believe that the disease often exists without the presence of exophthalmos or of thyroid enlargement, there being simply tumultuous action of the heart, to which, after a time, is superadded enlargement and excessive action of the vessels of the neck, later goitre, and still later exophthalmos. With this affection there is not necessarily any valvular disease. However, in this case, I find on percussion, enlargement of the area of cardiac dullness, which begins at the second interspace and extends to the sixth, and transversely extends from the right of the sternum to one inch outside of the nipple. Auscultation shows a systolic murmur, best heard at the apex and propagated to the angle of the scapula. This indicates mitral regurgitation. This murmur is also heard at the aortic and pulmonary cartilages, but it is by no means so loud in these positions as at the apex. We may have in this affection a murmur which is of hemic origin, and which will be best heard at the pulmonary cartilage. This is not the case here. We have other evidences of valvular disease in the condition of the feet and legs, which are the seat of positive edema. The edema has decidedly lessened during the four days that she has been kept in bed. The dropsy involves both legs, so that we know that the cause is a general one. If there were edema of only one leg, we should expect to find some local cause, such as enlarged glands in the groin, obstructing the return of blood through the veins. There is another possible cause of the edema which is present; a cause which, I think, is dependent upon the condition of the heart. There is also albuminuria, but this is not severe, and is not accompanied with casts. The presence of albumin in the urine without casts is in favor of the view that there is is no organic disease of the kidney, but that there is simply congestion in consequence of the cardiac trouble. I have therefore demonstrated that there is not only Graves' disease, but that this is complicated by insufficiency of the mitral valve. Looking back over the history, you will recall that she had a slight attack of rheumatism, and it is probable that the mitral insufficiency dates from that attack. We know that in many cases valvular disease escapes recognition until the patient is weakened by other causes. A condition which may be well borne when the individual is in good general health, but at once begins to give trouble when some other cause of weakness is superadded.

Graves' disease is an interesting one. It is sufficiently common to demand some attention on your part. In the first place, can we detect any cause for this disease? In the present instance we are unable to say what was the cause. There appears to be nothing in the previous life of the patient which would predispose her to this affection. There have been none of the conditions which are usually assigned as causes of this disease. Exophthalmic goitre often develops in anemic women, in women who have suffered from menorrhagia, or who have been debilitated from other causes, as excessive lactation, or by causes influencing the emotions. None of these conditions seem to have been present in this case. She menstruated normally until the occurrence of the menopause, which gave no special trouble. She has not had hemorrhages from any cause. She does not suffer from hemorrhoids which may cause loss of blood. There have been no influences acting upon her emotional nature. I have seen this disease in girls who have been disappointed in love, and in men who have been the subject of severe mental shock. So far as we have been able to ascertain, there is nothing in her history that will serve to explain the disease. In this connection, I recall the case of a boy aged 14 years who was sent to me for diagnosis. In his case the disease seemed to have been caused by seeing a fellow-scholar die of heart disease. This boy eventually recovered entirely.

The explanation of the phenomena is difficult. It has been attributed by some to lesions of the sympathetic nerves, and in a certain number of cases lesion of the sympathetic ganglia have been found after death, but in other cases no such lesions have been found. It has also been attributed to paralysis of the vaso-motor nerves, this explanation being based upon the dilatation of the vessels which is present. It is, however, difficult to understand how paralysis can give rise to increased action of the heart. Paralysis of the vaso-motor nerves would be expected to cause slowing of the heart. An attempt has been made to meet this objection by assuming that the coronary vessels are enlarged, and hence a larger amount of blood goes to the cardiac ganglia, which are thus stimulated to increased action. It has also been said that where there is diminished pressure in the vessels there must be increased action of the heart. There is in this disease dilatation of the vessels, and as a result, there is increased action of the heart. These explanations, while ingenious, do not appear to be entirely satisfactory. The fact, however, remains, that we have these symptoms, and in a certain number of cases lesions of the sympathetic ganglia have been found. There is often so much dilatation of the vessels of the thyroid that this body distinctly pulsates, and auscultation reveals such murmurs as are heard in aneurismal varix. That there is simply dilatation of the vessels is shown by the fact that the thyroid body may return to its normal size when health is restored. This would hardly be the case if the enlargement were due to increased growth.

The prominence of the eyeball has been attributed by some to dropsy of the globe, but this has been shown not to be the case. It has again been supposed to be due to an increased deposit of fat behind the ball, but this has also not been found. From the fact that the prominence of the eyes disappears after death, I believe that it is due to enlargement of the vessels back of the eyeball. The protrusion of the ball has been attributed by some to pressure of the thyroid upon the sympathetic nerve, but opposed to this view is the fact that in many cases there is no relation between the size of the thyroid body and the prominence of the eyeballs. In cases of ordinary goitre, there may be great enlargement of the thyroid with no prominence of the eyeballs. Accompanying the prominence of the eyeballs, we are apt to have some loss of consensual movement between the eyeball and the eyelid, so that when the patient looks up, the lids do not follow the movement of the balls. Here the prominence is not marked, and this symptom is wanting. In certain cases the prominence is so great that the lids cannot close over the ball, and it is said that in certain extreme cases the lids actually close behind it. I have, however, never seen a case so severe as that. In cases where the lids can not cover the ball, there is liable to be ulceration of the cornea. In order that the eyeball may remain in good condition, it is essential that it shall be kept constantly lubricated by the lid. Where this does not take place, dust collects and causes irritation and often ulceration. This is sometimes seen in typhoid fever, where the patient passes into a condition of coma vigil.

A word in reference to diagnosis. There is here no difficulty. We have three of the important symptoms which accompany this disease—the tumultuous action of the heart, the prominence of the eyeballs, and the dilatation of the arteries of the neck. There is also a systolic murmur heard in the arteries of the neck. The absence of enlargement of the thyroid body is not to be taken into consideration for a moment as invalidating this diagnosis. As I have said, in a certain number of cases it is absent, just as protrusion of the eyeballs may be wanting. It is sufficient, if there is tumultuous action of the heart with excessive pulsation of the arteries of the neck.

The prognosis of this disease as regards life is favorable. Patients rarely die from the disease, but it of course renders them less able to resist other diseases. While not strictly curable by medicines, much may be done by treatment to relieve some of its most distressing symptoms. In this case the prognosis is somewhat more serious in consequence of the valvular disease.

We come now to what is really the most difficult part of all, and that is the treatment. A great many different drugs have been recommended for the treatment of Graves' disease, and that fact alone shows that there is no specific for it. But while we cannot say of any one medicine that it will effect a cure in this disease, there are several remedies which will favorably influence its course. These remedies are not all of them medicines. Unquestionably in this case the rest which the patient has obtained in the hospital has been of great service to her, and already the symptoms are less marked than when she was admitted. The first thing, then, to be done, is to remove the patient from the conditions which predispose to the disease. If there is hemorrhage from any cause, this should be checked. If the patient is harassed by domestic duties, you will find that placing her in a hospital with freedom from care and exertion will cause great improvement.

As a rule in these cases, the heart, in spite of its tumultuous action, is really weak. It is therefore not proper in the immense majority of cases to give depressing remedies. I would rather give digitalis, therefore, than aconite. In this case I have given ten-drop doses of the tincture of digitalis three or four times a day. The valvular trouble which is present is also best treated by digitalis, so that we meet both indications with one remedy. If there is much anemia, iron should also be given. Dr. Austin Flint, Sr., depended a great deal on the use of reduced iron. He combined with this small doses of aconite. Iodide of potassium has been given by some with the view of reducing the enlargement of the thyroid body. As the enlargement of the thyroid is due to dilatation of the vessels, iodide of potassium seems scarcely to be indicated. In my hands, it has not been productive of good. Iodine has also been applied locally and given internally. Iodide of iron has been used and may be given where there is anemia, or in scrofulous individuals. As a rule, the best results are obtained by rest, good food, removal of all excitement and exertion, with the administration of digitalis and iron. The patients will generally get well in the course of four or five years. The recovery is, however, rarely complete, a slight degree of enlargement of the thyroid body, with some prominence of the eyeballs and irritability of the heart, being left in most cases after the subsidence of the more active symptoms.

## THE DEATH RATE OF SAN FRANCISCO.

By J. H. Stallard, M. B., Lond., M. R. C. P., San Francisco, Cal.

*Read Before the San Francisco County Medical Society.*

In his last annual report, Dr. Barger has estimated the population of San Francisco at 300,000, exclusive of the Chinese—and the death rate at 18.36 per thousand. In the year 1888 there were 5,510 deaths, which gives the same figures. For the first time, the Health Officer has wisely refrained from making comparisons with other cities, nor has he offered to the citizens of San Francisco the usual congratulations on the low rate of mortality. Indeed, in the face of the acknowledged mortality from preventable disease, such congratulations have always been misplaced. So long as the public are deluded by a mere statement of figures, it will be hopeless to expect any serious effort to advance sanitary improvement. An individual may be at the point of death, but if he is ignorant of his true condition and feels well, he is not inclined to listen to a doctor and much less to pay for his advice or medicine.

It is not altogether surprising that the citizens of San Francisco should be in this condition. They read of cities where the ordinary annual rate of mortality is over 30 in the thousand. They are not afflicted with cyclones and sun strokes. They know nothing of yellow fever and but little of malaria as compared with other localities. They see the ruddy complexions of their healthy children, amongst whom rickets is unknown and scrofula rare. In this new and cosmopolitan community old age is often hale, and centenarians are by no means curiosities. Many of the prevalent diseases are obviously self-induced—men work hard—drink hard —feed highly, and are subject to nervous overstrain.

The climate itself is highly stimulating, the outlook satisfactory, and there is no tendency to meet troubles half way. The municipal authorities only represent public feeling when they let questions of public sanitation go by the board. In the schools, the cultivation of the intellect stands before the cultivation of the body. It is more glorious to add a tower to the city hall, than to put the sewers in a wholesome state. New wharves are built upon the water front, while the horrors of Butchertown go on untouched. It is troublesome to burn the garbage and so it is dumped for filling in, to the detriment of generations who may hereafter build upon it. Indeed, it would seem that nothing short of a fatal epidemic of cholera would arouse the people to the sanitary dangers which beset them.

Nothing has contributed so much to this state of things as the repeated assertions that we have a favorable death rate; but the question is never suggested that this favorable showing is a complete delusion. Every community has a special death rate, which is determined primarily by the nature and conditions of the population. An army in the field has not the death rate of the same army in time of peace. It would be absurd to compare the death rate of the Industrial School with that of the Almshouse. The annual mortality of boys and girls between ten and fifteen years of age is only five per thousand, whilst that of persons over 60 years of age is, for males, 68.54, and for females, 57.32 per thousand.

Much of the lower death rate of San Francisco may be clearly explained by the peculiar character of the population. This is a young city, composed very largely of persons who have arrived here in the very prime of life. There is a deficiency of infants. Of 100 persons there are—

| | In England. | In San Francisco. |
|---|---|---|
| Under 20 years of age, | 59 | 41 |
| “ 25 “ “ | 10 | 9 |
| “ 35 “ “ | 12 | 18 |
| “ 45 “ “ | 9 | 16 |
| “ 55 “ “ | 6 | 10 |
| “ 65 “ “ | 3 | 4.1 |
| Over 65 “ “ | 1 | 1.6 |

A further effect of immigration is an excess of males. In the prime years of life—from 20 to 30 years of age—there are in San Francisco at least three males to two females, whilst it is the reverse in older cities. In San Francisco the registration of births is so defective that it is impossible to say how large a number of children die within the first years of life. We thus lose one of the best criterions of the public health. In San Francisco there is a great preponderance of persons in the prime of life; that is, from 25 to 55 years of age, the natural death rate of whom is certainly not more than 12.5 per thousand. It is not to be wondered, therefore, that our death rate should be lower than that of older cities which have 10 or 20 per cent. less of this particular class. And yet there are several largely populated towns in England where the annual death rate is 3 and 4 per thousand less than that of San Francisco, and the annual death rate of London for 1888 is only 18.3 per thousand, or something less than San Francisco. During one quarter of 1888 the death rate of London was at the annual rate of 15 in the thousand.

I am therefore prepared to maintain that, if the normal death rate of an old established city should be 20 in the thousand, with the specially favorable conditions found in San Francisco, both as regards climate, prosperity and age, it should not be more than 15; and this is equivalent to stating that 1,375 deaths of the 5,510 which occurred last year are due to causes which are within our own control. I will this evening only direct your attention to two diseases, viz: typhoid fever and diphtheria. I shall assume that they are the result of uncleanliness, and it would not be difficult to prove that they are diminished in frequency, if not destroyed entirely, by effective public sanitation.

In 1888 there were 158 deaths from typhoid fever, and 111 from diphtheria. That is, there were 52.6 deaths from typhoid for 100,000 people, and 37 deaths from diphtheria for the same number. Now, compare this with London, a population which can bear no comparison with that of San Francisco for salubrity, general prosperity, or age, and yet the mortality from typhoid fever in London was only 16.3 per 100,000, and that from diphtheria, which was unusually fatal during a portion of the year, 30 per 100,000. In the most poverty-stricken and most densely crowded parts of London, viz., Bethnal Green, Whitechapel and Shoreditch, the mortality from typhoid and diphtheria in a population of 325,000, was at the rate 13 per 100,000 from typhoid, and 33 per 100,000 from diphtheria.

In my native town of Leicester, about half the size of San Francisco, which fifty years ago was the home of typhoid fever, there were, in 1887, 31 deaths from typhoid, and only 13 from diphtheria. In that city every case of typhoid and diphtheria is reported to the health office; altogether 444 cases of typhoid and 162 of diphtheria. If, in 1887, the sanitary condition of San Francisco were as good as that of Leicester, 185 lives would have been saved from diphtheria, and more than 1000 children would have escaped attack; 30 lives would have been saved from typhoid, and 213 persons would have escaped attack.

It would be desirable to study the progress of sanitation and its effect on the diminution of other preventable diseases. Not the least interesting is the great diminution of phthisis in England during the last three decades, of which the figures are as follows:

PHTHISIS IN ENGLAND AND WALES.

| | All ages. | 15 | 20 | 25 | 35 |
|---|---|---|---|---|---|
| 1851–'60 | 2679 | 2961 | 4181 | 4317 | 4091 |
| 1861–'70 | 2475 | 2651 | 3928 | 4243 | 4026 |
| 1871–'80 | 2116 | 2036 | 3117 | 3619 | 3741 |

These figures at least prove that the deaths from consumption are susceptible of great diminution, and that the hope of eradicating this fatal disorder is not entirely chimerical.

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## ON THE RELATION BETWEEN GENERALISTS AND SPECIALISTS.

*Read before the Northern District Medical Society.*

By HAMILTON STILLSON, M. A., M. D., Ph. D., Red Bluff, Cal.

I wish to call your attention to the relation between the general practitioner and the specialist in the practice of medicine and surgery, and believing, as I do, that this relation is much more important than is generally supposed, I submit three propositions for your consideration.

(1) The relation between specialists and generalists is intimate. This surely is evident from the nature of things, and can be shown to be so by three considerations.

(*a*) No specialist can confine his attention or treatment strictly to one region of the body, for the reason that on account of its anatomical arrangement no organ or set of organs is wholly separate from any other, either in influence or operation. A prominent medical author remarks: "Patients judge of the position of their own disease most frequently by the situation of the most prominent painful symptoms, whilst we surgeons know by experience that such symptoms may exhibit themselves at a spot far removed from the seat of the disease." Thus, intestinal ulceration may have its origin in a surface burn, and occipital neuralgia its source in metritis. Inflammation at the periphery of a nerve may cause a central lesion, as when convulsions are due to preputial inflammation or intestinal entozoa, and central myelitis may manifest itself in peripheral abdominal pains. Anasarca in the feet, and paralysis of the hand are not dependent upon a local cause. And so, I say, from the intimate anatomical and physiological relationship of all parts of the body, there follows an intimate relation between the specialist and the generalist.

(*b*) But it follows also from another fact, viz: that their interdependence in diagnosis and treatment is great. Many cases are wholly neglected, and many others go to the bad, because generalists and specialists do not coöperate. The specialist, perhaps, confines himself too closely to his specialty, or the generalist fails to avail himself of a consultation. A patient has earache, we will say, and the aurist treats the ear, only to find that it gets worse. It is caused, perhaps, by an ulcer upon the tongue, which finally becomes so bad that the sufferer calls on his family physician, who applies caustics to the tongue and only makes it worse, for the ulcer is caused by the sharp edge of a decayed tooth, which finally becomes so sensitive that the patient applies to a dentist, who smoothes the offending tooth and relieves all the trouble. This is no fancy sketch, but the report of a case from actual practice, given by a former member of the staff of Guy's Hospital. How much more satisfactory it would have been to all concerned if these physicians had been less exclusive, and had condescended to consult at the beginning of the case.

When the dentist sends his patient to the family physician to be treated for neuralgia, stating that the neuralgia depends upon anemia rather than upon any fault in the teeth, he recognizes this relationship of which we speak. When the oculist returns the patient to her family physician to have the urine examined for the presence of albumin as the cause of the ambliopia—thinking that the albuminuria itself may arise from some ulterior cause, as gestation—he recognizes this relationship, and in thus coöperating, these physicians advance their own interests, the welfare of the patient, and the standing of the profession they espouse.

(*c*) But a third consideration which shows this relation to be intimate is, that patients desire it to be so. The public are fast becoming educated up to the point of employing specialists, and it is now very common for patients to go to the large cities for special treatment, which they often do without the advice or consent of the family physician. Whatever be the cause of this, it is certain that, if generalists and specialists were more cordial in their coöperation, many of these patients would not leave their physicians, and many others, having left, would be returned; for we all know that many of these cases are best treated at their homes, under the supervision of the family physician, who knows best their environments and idiosyncrasies.

This leads us to the second proposition, viz: that this relation is not only intimate, but one of mutual benefit. In support of this proposition, let me submit three establishing facts.

(*a*) From what has been said it would follow that the generalist and the specialist may greatly assist each other in the diagnosis and treatment of disease. The following case, reported by Mr. Hilton, is sufficient for the purpose of illustration. A young woman who had formerly been fond of society was seen to become retiring in her disposition, no longer loved dancing, preferred lying in bed, her menstruation became very irregular or wholly suppressed; her abdomen became decidedly increased in size, so that a surgeon was called who mentioned a suspicion of pregnancy, and recommended that she be taken to Dr. Golding Bird, who, when he had examined her, replied: "No, she is not in the family way. I think she has something the matter with her rectum. Take her to Mr. Hilton." It was then found by Mr. Hilton that an anal ulcer was the primary cause of the whole trouble.

(*b*) But aside from the mutual benefit derived from coöperation, we must remember that by failing to coöperate we often thwart each other's purpose. The specialist may unwittingly endeavor to treat symptoms due wholly to the treatment which the patient may be undergoing from the general practitioner. The patient complains of ringing in the ears. This the aurist endeavors to treat. The trouble gets worse; the patient is taking heroic doses of quinine, prescribed by the family physician for malaria. The dentist is endeavoring to get the patient's gums in a condition of health that will admit of his working on the teeth. The gums get worse. He does not know that the patient is taking mercury for his syphilis, and so, we blow contrary winds. Is not this unscientific and undesirable?

(*c*) But this relation is mutually beneficial in the increased skill developed on both sides. There is no generalist who is not also some sort of a specialist in that there is some disease or surgical operation to which he prefers to attend, or for which he is better prepared than for any other. By consulting freely with specialists, he throws this study and effort into given and well directed channels, and makes himself proficient.

(3) My third proposition follows, then, as a matter of course. It is this, that the intimate and beneficial relation between specialists and general practitioners should be recognized and encouraged. It should be encouraged for the sake of the physician himself, and for the sake of the science and art which we would thereby promote. It should be encouraged for the sake of the patient whose good we seek, and for whose physical welfare we daily make personal sacrifice. How many neglected cases are there? Here is a man blind from cataract; not because there are not surgeons who would gladly give the poor fellow the benefit of their skill, but because the family physician fails to direct the patient to the light. Here is a child suffering with strabismus, not because he cannot be easily and certainly cured, but because it is neglected. Such cases are monuments of our neglect. Nor will it be sufficient that they come under treatment when it is too late to do them any good. It surely is little to our credit to temporize with a case of otitis media purulenta—the sequela of scarlatina—until the membrana tympani has been destroyed, and then expect the aurist to create anew the lost organ. The specialist in throat diseases has nothing that troubles him more than those cases which ask him to undo the results of neglect in diphtheria, scarlatina, and other general diseases affecting the throat. A little well directed special treatment at the proper time would have averted the permanent after-trouble, and assisted the general practitioner in the rational treatment of the disease.

In conclusion, then, may we not express the hope that from motives of self-interest, if not from humanitarian desires, specialists and generalists will draw more closely together in their operations, as they are now in their interests.

# MEMORANDA.

### A Case of Dextrocardia.

A. J——, æt. 30 years, has suffered from pleurisy, which he believes to have been on the right side, when he was seven years old. Had pneumonia on the left side when thirteen years of age. Seven years since had a hemorrhage; has had hemoptyses at intervals ever since, though never serious. For four years has been steadily losing flesh, the expectoration being meanwhile continuous. Dr. W. A. Briggs, who kindly examined the case with me, concurs as to his present condition. Right lung consolidated; very little air entering base; probably small cavity near apex, and posteriorly. Left lung breaking down; Moist *râles* all over upper and posterior portion of chest. Heart situated on right side, as nearly as possible in the position corresponding to its normal situation on the left side. Area of cardiac dulness enlarged, and merged into the normal dulness of the hepatic region. Patient says that, as long as he can remember, his heart "has been beating in the wrong place," but that he has never apparently been affected by the abnormity.

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# DEPARTMENTS.

## OBSTETRICS, GYNECOLOGY AND PEDIATRICS.

By WALLACE A. BRIGGS, M. D., Sacramento, Cal.

**Extrauterine Gestation.**—DR. PERRIN says that treatment by abdominal section is applicable whether rupture has occurred or not, but in the former it seems imperative. Others beside Mr. Tait have had valuable experience in the surgical treatment of this affection, though none probably a tithe of his; thus, Worth has operated seven times with six recoveries, and so firmly convinced is he of the importance of abdominal section, that he declares an extrauterine gestation ought to be treated as a malignant tumor—extirpated at the earliest moment. Having witnessed several operations for extrauterine pregnancy with uniformly favorable results, I am more and more convinced that this is the method of treatment for all cases, the only exceptions being (*a*) an abdominal pregnancy so far advanced that there would be hope of extracting a living child, at term when the operation might be deferred until near the close of pregnancy, and (*b*) an unruptured interstitial pregnancy.—*Coll. and Clin. Record*, Jan., 1889.

**Infantile Convulsions.**—DR. LOVE, in his paper, emphasizes the following points: (1) Convulsion is a symptom, not a disease: its cause should be promptly determined and removed. (2) The majority of cases of convulsions are caused by (*a*) ill fed nerve centres (rachitis and tuberculosis), (*b*) reflex irritations, and (*c*) high temperature. (3) The treatment should correspond to the etiological classification: (*a*) nutritive and constructive, (*b*) removal of all local irritation, (*c*) antiphlogistic, eliminative and sedative. (4) An accurate thermometer (the doctor's sixth sense), is of the utmost importance in determining the condition, and should be inserted in the rectum and left *in situ* not less than three minutes. (5) Chloroform is a valuable means of promptly controlling the spasm, but it should be used carefully and not too early. (6) The cooling bath beginning at about the temperature of the patient and gradually reduced to 70°, or even 60° F., and possibly lower, is a prompt and powerful means of quieting the nervous disturbance. (7) In acetanilid I am sure we have a most valuable remedy for the relief and prevention of convulsions. Its action is rapid, frequently manifesting itself within twenty minutes, usually within half an hour, and reaching its maximum in four hours.—*Cincinnati Lancet-Clinic*, Jan. 26, 1889.

**Pelvic Cellulitis.**—DR. SKENE concludes that: (1) Uncomplicated pelvic cellulitis occurs frequently. (2) Subperitoneal pelvic hematocle should be recognized as one of its causes. (3) In suitable cases aspiration may be employed with advantage before, as well as after, suppuration. (4) Abscess of the cellular tissue of the pelvis should be opened from the vagina when the conditions are favorable. (5) Laparotomy is advisable when the vaginal wall is not closely adherent to the abscess sac. (6) Laparotomy should be done when a pelvic abscess opens into the bladder and suppuration continues. (7) Cellulitis may extend to the psoas muscle and give rise to psoas abscess.—*Brooklyn Medical Journal*, Jan., 1889.

**Pelvic Measurements.**—From a careful study, DR. PERSHING presents the following conclusions: (1) Measurements are not to be regarded as necessary only in rare cases, and hence but rarely employed. On the contrary, the pelvis of every pregnant woman should be examined when she is received as a patient, or as soon afterward as possible. On this point Spiegelberg says: "It cannot be too urgently impressed that the pelvis is to be included in the examination of every pregnant and parturient woman, even when there is not the least suspicion of contraction. In this way not only will the overlooking of anomalies be avoided, but the obstetrician will be prevented from finding himself at some time during labor brought face to face with difficulties of which he had no presentiment, and which, with timely knowledge, he might have avoided, or at least made less formidable." The fortunate termination of previous labors by no means does away with the necessity for this examination. It is an undoubted fact, amply sustained by experience, that in cases of contraction the difficulties tend to increase with the number of labors, and while the first and second labors may end favorably, later ones may require the severest operative procedures. (2) The examination should consist in measurement of the external conjugate, anterior and posterior iliac spines and iliac crests. If these external measurements indicate a normal pelvis the examination may end with them. But if contraction is suspected, the diagonal conjugate and the oblique ascending diameter of Löhlein should be taken. These measurements should be considered in the light thrown on them by the previous history and general condition of the patient, and especially by a careful internal and external palpation of the pelvic bones, which will reveal the necessity, if it exists, of further measurements.—*American Jour. of Med. Sciences*, Feb., 1889.

**The Etiology of Diphtheria.**—DR. RACHFORD summarizes the results of his study as follows: (1) Diphtheria is a purely local disease. (2) It is caused by an external parasite. (3) This parasite is practically, if not strictly, aërobic. (4) The constitutional symptoms are due to the absorption of poisonous materials, viz., ptomaines, from the local lesion. (5) The changes occurring in the blood and tissues are caused by direct or indirect action of ptomaines. (6) This disease has no latent stages, and second and third attacks are due to reinfection. (7) One attack, as a rule, gives at least temporary immunity. (8) After the limited period of immunity has expired, the previous attack may act as a predisposing cause to other attacks, if it has left the mucous membrane of the throat in an irritated and inflamed condition. This is more likely to occur in the scrofulous. (9) Complications may occur from the entrance into the body of septic germs. Upon these propositions may be based the following rules of treatment: (1) Dissolve away the membrane if possible, and irrigate thoroughly and frequently, with an antiseptic solution the local lesion, for the double purpose of washing away the poisonous alkaloids and retarding the growth of the parasites. (2) In diphtheria of wounds, and in other parts where it is practicable, the thorough irrigation should be followed by a dressing which would exclude the atmospheric air. This on account of the aërobic nature of the germ. (3) We should try to relieve the system of the poisonous alkaloids by mild catharsis, free diuresis and diaphoresis, with remedies which do not have a depressing action on the heart. (4) We should seek to counteract the depressing effects of this poison on the heart and other tissues by abundant stimulation. (5) We should also seek to counteract its deteriorating influence on the blood by the free exhibition of the great blood restorer, iron. (6) We should render the air of the sick room as nearly aseptic as possible, to prevent the entrance of adventitious septic germs. (7) Chronic glandular enlargement, or other local diseases in or about the throat, left as the sequel of diphtheria, should be given the most careful consideration, and, if possible, should be thoroughly cured before dismissal. If this cannot be done, the patient should be warned against future exposure to the diphtheritic poison. (8) The patient should not be entirely dismissed from observation for two months after the attack, and during this time with tonics and judicious feeding we should assist nature in restoring the blood and tissues to their normal condition that they may resist the degenerative nerve changes which cause after paralysis. (9) A serious exacerbation of the symptoms in any form of ulceration or catarrh of the stomach or intestines occurring in a patient exposed to the diphtheritic poison, should lead us to suspect diphtheria of these parts, and we should treat the case accordingly.—*Medical News*, Feb. 2, 1889.

## SURGERY.

By T. W. HUNTINGTON, B. A., M. D., Surgeon Southern Pacific Company's Hospital, Sacramento, Cal., and J. F. MORSE, M. D., Surgeon German Hospital, San Francisco, Cal.

**Extraction from the Stomach of a Tooth Brush Swallowed Fifteen Years Prior.**—DR. HASHIMOTO reports (*Langenbeck's Archiv.* vol. 38, No. 1), the following case: K. Luy, a woman, aged 49 years, was admitted into the hospital of the Japanese Society of the Red Cross, October 17, 1887. Since her fourteenth year the patient has felt a fullness and pressure in the epigastrium after eating, and has had frequent sour evacuations. She vomited every morning, great quantities of slime by tickling the root of her tongue or pharynx with her finger or a Japanese tooth brush. In May, 1872, while engaged in this manipulation, she swallowed the tooth brush, in consequence of which she was seized with severe pains in the stomach and became feverish. She was obliged to fast, and passed sleepless nights. After several days her condition improved. In March, 1877, the pain in the region of the stomach again returned. An abscess formed at that point, which opened spontaneously, whereby 1 cm. of the sharp end of the tooth brush protruded. The attending physician tried in vain to extract it, and finally contented himself with cutting off the protruding portion. The wound thereupon healed, and left only a disagreeable feeling to the patient of the constant presence of the foreign body in the epigastrium. At the end of August, 1886, the pain and swelling returned; this time, however, lower down, in the region of the navel. On October 10th, a quantity of pus was evacuated at the navel itself, and several adjacent spots. After the escape of the pus, a hard body could be distinctly felt beneath the navel, pushing up the abdominal walls into a protuberance which was painful on pressure. It soon disappeared and left a fistulous passage. The final result was that the abdomen was opened along the canal of the fistula and a fragment of the brush extracted. The incision was extended until the opening in the stomach was exposed, the brush seized and pulled out. A large quantity of dense tissue which surrounded the opening was then scraped away, and the wound treated in the usual antiseptic manner. The patient recovered rapidly and perfectly. In preluding this report the Doctor speaks of a number of foreign bodies removed from the stomach and other parts, after having been swallowed. Professor Schönborn removed from the stomach of a fifteen-year old girl a mass of hair she had swallowed. Prof. Bardeleben removed from the ileo-cecal region a steel needle, which an eleven-year old girl had swallowed ten years previously. He also extracted from the abdomen a teaspoon, which had been swallowed nine months before operation. Le Fillier removed a fragmentary mass from the region of the left trochanter, in an insane person. It proved to be a fork, which had been swallowed five years before. Dubois removed from the iliac fossa a knife blade which had gone through the process of deglutition a considerable period before the patient appeared for operation. Nussbaum speaks of a butcher who once swallowed a sharpening steel, which was removed from the region of the epigastrium, and on a subsequent occasion he was relieved of a knife, which had located itself in the lumbar region, after having been swallowed.

**Anthrax Maligna.**—Among the most important infectious and contagious diseases are those which may be communicated from animals to man. Although few in number, they include some of the most dangerous maladies to which the human race is exposed. Success in treatment of malignant pustule depends mainly on the power to make an early and correct diagnosis. Careful investigations in the past few years prove that anthrax in man is due to the presence in the blood or tissues, or both, of the specific spherical and linear bacteria, known as micrococcus and bacillus anthrasis. Spontaneous development of the disease, apart from the presence of the bacilli in animals or soil, is, therefore, impossible. The bacilli are destroyed at a temperature of 145° F., but the spores withstand the temperature of boiling from five to ten minutes, while exposure to a temperature as low as 1° F. simply renders them dormant, but does not destroy them. In man, the principle modes of infection are direct and indirect. The direct include the handling of sick animals, carcasses, hides, etc. Physicians and nurses have been inoculated by their patients, and examples of infection by eating cheese, milk and cream are recorded. Among the indirect, are inoculation through the bites of insects, and by water containing the poison. In many cases it is clearly impossible to establish the source of infection. The disease usually attacks some exposed part of the body, the upper extremity and face being favorite situations. Of 1,000 cases collected by Koch, 370 were of the upper extremity, 490 of the head and face, and only 26 of the lower extremity. Of the three varieties, primary anthrax carbuncle (malignant pustule), malignant anthrax edema, and internal anthrax, the first only is considered in this article. Incubation varies from a few hours to twelve days. Where the poison has entered the skin there is felt a burning or itching sensation, and inspection reveals a small red spot with a dark center. This spot gradually enlarges into a small papule, and in a few hours there appears on its summit a small vesicle containing reddish-brown serum. On the rupture of the vesicle, the itching ceases and the skin beneath it seems to be of a brown or a black color, and a local eschar forms. The surrounding skin forms an elevated, livid, red, area, on which, in a few hours, appear small vesicles, similar to the first, and which pass through the same stages, leaving beneath a gangrenous surface. The eschar is now depressed, black, has a feeling like leather, is perfectly dry, and is not painful on pressure. The parts beneath swell and form a hard, well-defined lump, which can be raised from the tissues; occasionally the swelling is absent. The swelling of the skin increases, the color changes from red to dark blue, new vesicles appear, the eschar increases through their rupture, and the disease keeps steadily extending. The affected part becomes the centre of an ill-defined edematous swelling, and the edema may invade the entire arm, face or neck. A striking symptom is the little pain these swellings cause, and the occurrence of pain in them is a favorable sign of commencing reaction. When the disease is on the trunk or extremities, inflamed lymphatics are sometimes seen extending to the neighboring glands. Such is the usual but not invariable course of primary anthrax carbuncle. The disease lasts, on an average, from six to ten days, and for the first forty-eight to sixty hours it is local, and afterward the system is infected. The constitutional symptoms in favorable cases are headache, slight fever and signs of general depression; in fatal cases are observed septicemia, often followed by collapse. Prognosis in external anthrax is dependent on certain conditions. In anthrax districts the mortality is from five to nine per cent.; outside of these districts the mortality is as high as forty to fifty per cent. The difference is easily explained, as in districts where the disease frequently occurs, medical aid is sought early, and the physicians, from experience, are able to make a rapid and correct diagnosis, and energetic treatment is carried out while the disease is local. At this stage the treatment is purely surgical, and it should be carried out in a *thoroughly antiseptic manner*. The eschar, together with a small zone of the adjacent tissue should be excised, the wound cauterized or filled with powdered corrosive sublimate, or both, then a 1:2000 bichloride dressing should be applied over the affected part. Bichloride of mercury is the best antiseptic to use, as from recent experiments it has been shown to be superior to carbolic acid, iodine, salicylic acid and other agents in destroying more rapidly the germs of anthrax. After excising the pustule, one must carefully disinfect the instruments, hands, in fact everything which has come in contact with diseased tissues. FRANCIS W. MURRAY, M. D.—*New York Medical Journal.*

**Surgical Shock.**—Upon this most important topic CHRISTOPHER HEATH, F. R. C. S., has this to say: While many surgeons, myself among the number, rarely employ the carbolic spray nowadays, yet even without this there is, I believe, considerably increased risk to patients in the exaggerated slowness of modern surgery. For a patient to breathe the vapor of ether or chloroform for over an hour is a serious matter for both heart and lungs; and when we add to that a steady drain of blood going on for an equal time, one cannot be surprised at the production of deadly shock. And is there any gain after all in elaborate dissections of the living as though it were a dead body? I believe not; and, having had a fair amount of experience in removing tumors of all sizes from all parts of the body, I would urge surgeons to use the left hand a little more and the right a little less than now seems to be the fashion. I mean, to make forcible traction with the one hand whilst avoiding the tense structures with the other, so as to avoid dissecting-room proceedings with scalpel and forceps as much as might be. I hope I shall not be misunderstood as decrying careful dissection in appropriate cases—for example, the ligature of large arteries; for I fear, from what I see in examining candidates for the higher surgical degrees, that a blunt director must be used by some teachers in what I consider to be a very dangerous manner. The following guards against shock are strongly recommended; a rectal injection of brandy and hot water prior to, and a subcutaneous injection of morphine and atropine after an operation.—*British Medical Journal.*

**Trephining the Mastoid.**—DR. MITZKUNA proposes a new locality for trephining the mastoid process, the point of trephining to be found thus: The ear is drawn forward, whereby a fold (of the skin) is formed just behind the ear. Under this, a flat, bony prominence is felt. Between this prominence and the base of the mastoid process, is a depression, which depression is the place for trephining. The advantages of this locality over others is: (1) That a chisel can descend from one-fourth to one-third of an inch with safety. (2) That the transverse sinus, which takes a different course in different people, never touches this point. (3) That the thickness of the temporal bone is greatest at this point. (4) The only drawback of this locality is the possibility of going through the external auditory canal, but even this is nothing when compared to the possibility and danger of injuring the transverse sinus.—*Wiener klin. Wochenschr.* —*Medical News.*

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## OPHTHALMOLOGY, OTOLOGY AND LARYNGOLOGY.

By Wm. Ellery Briggs, M.D., Sacramento, Cal.

**Treatment of Serpiginous Ulcers of the Cornea.**—In the treatment of serpiginous ulcers of the cornea, Dr. Dehenne advises the following course: (1) Open the lachyrmal ducts and irrigate the passages with an antiseptic solution (boric acid 4:100). (2) Wash out the conjunctival *cul-de-sac* with sublimate solution, 1:2000. (3) Cauterize the surface of the corneal ulcer by the aid of a fine pointed thermo-cautery at a white heat. (4) If there is pus in the anterior chamber, perforate the cornea with the same point and evacuate the pus. (5) Instill five or six drops of neutral sulphate of eserine solution (1:200) four times daily.—*Union Medical*, January 1, 1889.

**Some Practical Hints in Connection with Intubation of the Larynx.** —In the *New York Medical Journal* of February 2, 1889, Dr. J. Mount Bleyer gives a *resumê* of 206 cases which he has intubed. Of the 206 cases operated upon, 67 (33 per cent.) recovered. Out of 107 there were 24 recoveries in children under three years of age, and in 99, three years and over, there were 43 recoveries. He lays stress on the importance of making a laryngoscopic examination before and after the introduction of the tube. This is facilitated by the use of his gag and tongue tractor. In the last fifty cases he has extracted the tube daily. This was done to facilitate the removal of accumulations of loose membranes, tenacious mucus, pus, etc., which might block up the tube or the pharyngeal and laryngeal surfaces. After the employment of this measure it was found that the little patient could rid itself of a large amount of blocking and poisonous *dêbris.* When the tube is extracted he irrigates the posterior nares, pharynx and larynx, with half an ounce of bicarbonate of sodium to fourteen ounces of luke-warm water. Half an hour later food is given which is often taken ravenously. If any difficulty is experienced at this stage, the stomach tube is used. After food is given the tube is reintroduced, except in cases in which the stenosis is not urgent, when some hours may intervene before reintroducing it. In a large number of cases it was found that the tube had completed its service on the second or third day, and with few exceptions was not again introduced. The author attributes much benefit to irrigation of the mucous surfaces. He uses a No. 8 soft rubber catheter attached to a fountain syringe. The fluid used is made by taking peroxide of hydrogen (Charles Marchand's), fifteen volume solution, chemically pure, one ounce to twelve ounces of water. The nostrils should be first thoroughly washed out, then the mouth, pharnyx and larynx. For irrigating the larynx, use this solution diluted one-half. To wash these cavities out readily, the child's head should be held forward over a basin, the mouth well opened with the gag if necessary. If the fluid is swallowed no harm will be done, as it is a harmless antiseptic. The irrigation should begin early, while the membrane is still thin and fragile, and be repeated every two hours, or more frequently if necessary. The nurse can be taught to make the application with facility. The peroxide of hydrogen must be kept at a temperature below 65° F., as it begins to decompose slowly at that temperature.

**Removal of an Encapsulated Cysticercus from the Eye.**—In the *Archiv. f. Ophthalmologie* DR. STÖLTLING describes a successful operation for this rare affection. A soldier, æt. 20, who complained of loss of visual power of the right eye, was brought to him on August 17, 1888. Pain or irritation had not been present. A careful examination of the amount of obliteration of the visual field had not been made. Sight of left eye normal, while the right could only count fingers at 1.5 m. in eccentric fixation. On account of the great loss of vision the author was surprised to find the media clear. A slight vitreous haziness and a cyst near the posterior pole of the eye, and close to a slight choroidal circatrix, was observed. This cyst was about 8 mm. long, by 5 mm. wide, 6 mm. from the disc, external and somewhat above it. On the anterior surface of the cyst there was a depression which divided it nearly in the centre: The surface of the growth was a yellowish white color, with the exception of the outer upper border, which showed a white tendinous appearance. Here the vessels which were distributed over other parts of the growth were absent. The retinal vessels could not be traced in their course to the growth as the cyst walls overhung the retina where it spread over the cyst. Vitreous threads attached to the surface vibrated on motion of the eye, but there was no visible movement of the surface. Amotio retinæ was not present. External to and above the cyst a small triangular choroidal cicatrix could be seen. The conclusion was that an entozoon was encapsuled in the connective tissue and mostly covered with retina. During the next few weeks the only changes perceptible were a slight enlargement of the cyst, and thinning of the retinal covering, giving it an appearance as though it might soon rupture and pass into the vitreous. Dr. Stöltling attempted to remove the contents of the sac on August 28th. He operated according to the method described by Graeffe and Leber. After making the incision with the knife and enlarging it with a scissors, he expected to see the entozoon escape spontaneously. This hope was not, however, realized, and an effort to remove it with a hook was also unsuccessful, and the wound was closed to prevent too great escape of vitreous. Eight days later when an ophthalmoscopic examination was made, the operator was surprised to find that he had made the incision 1 mm. above the cyst. The tumor presented about the same appearance as before, and vision was unchanged. After about six weeks the operation was again undertaken. After enlarging the opening made by the knife with the scissors, the cyst was quickly caught by an iris forceps, requiring considerable traction and care to withdraw. A microscopic examination showed the cyst walls composed of degenerated retinal tissue. The small cysticercus was found within the cyst. The recovery was uninterrupted. The bandage being first removed after six days, the eye was free from irritation. Unfortunately the little sight which had previously been in the eye was absent from total detachment of the retina. The eye remained free from pain and irritation, with normal tension.

**A Case of Recurrent Transient Blindness.**—At the meeting of the British Ophthalmological Society, December 13, 1888, MR. DOYNE read the notes of a case with the following history : The patient had been invalided home from India after malarial fever. Before his return he had a sudden attack of blindness, which disappeared completely in five minutes. Another attack came on suddenly soon after his arrival in England, while drying himself after his morning bath, which, three weeks later, had not entirely passed off. When he first came under notice, two days after the attack, the upper half of the field of vision was restored. There was a dense white fog in the upper half of the fundus, completely veiling the choroid, but in which the retinal vessels stood out brilliantly. There was no plugging of any of the vessels, and the cause of the attack seemed doubtful. In the discussion, DR. ANDERSON described a case of almost symmetrical loss of the lower half of both fields of vision. The patient was the subject of ague, and the trouble came on after a long ride. The patient also had hemianesthesia, and undoubtedly had a lesion, probably vascular, affecting the visual area in the brain. DR. BERRY said that cases were often diagnosed as embolic, whereas they were due to spasmodic contraction of the arteries of the retina, producing blindness or scotoma. In one case he had actually seen the condition of constriction shortly after it had developed, and there was edema of the retina corresponding precisely to the scotoma. He believed there was an intimate relation between some of these cases and glaucoma. MR. HULKE doubted that arterial spasms could last for several hours. The patient had taken quinine, but as a rule quinine produced a long continued narrowing of the vessels.—*British Medical Journal.*

**Chloride of Sodium in Diphtheria.**—There seems to be no limit to the new methods recommended for the treatment of diphtheria. This arises from the fact that all known remedies fail in a large percentage of cases, and a certain plan may be successful in a series of cases and fail under less favorable conditions. DR. A. SEIBERT, of New York, had administered iodine, carbolic acid and sublimate to counteract the poison, but concluded that the minute doses in which these medicines were given must be inefficient. Believing that the non-irritating and antiseptic properties of common salt would permit its being used in sufficient quantity to destroy the germs of diphtheria, he applied powdered salt to the pharynx and tonsils, on the diseased and neighboring tissues. An effort is made to keep the salt in contact with the tissues for some moments. This treatment should be commenced in the beginning of the disease and two daily applications made. The author does not give statistics of cases so treated, but says that his experience has been satisfactory.—*Medicinische Monatschrift*, Jan., 1889.

## DERMATOLOGY AND VENEREAL DISEASES.

By G. L. SIMMONS, JR., M.D., Sacramento, Cal.
And D. W. MONTGOMERY, M.D., Professor of Pathology, University of California, San Francisco.

**Leprosy.**—In the *British Medical Journal* of January 12th, 1889, an extract is given from a very interesting contribution by DR. ZURIAGA in the *Annales de Dermet.*, vol. ix, No. 6, on the transmission of leprosy. There was no leprosy in the village of Parcent, Province of Alicante, Spain, in 1849. In 1850 a leper from a neighboring town came to live at Parcent, staying with an intimate friend, Vincent Poquet Andres. They ate, drank and slept together, and within the first year Andres had acquired leprosy. A nephew of Andres, named Ramont Poquet Perez, frequenting the house of his uncle, became infected in a short time. Perez, the nephew, had three married brothers named Baptiste, Joseph and Rosa. Fearing the disease, Baptiste and Rosa shunned Ramont; but Joseph and his children were less careful. In a very short time five of Joseph's children had acquired leprosy; the other two children, from fear of the disease, left their father's house, cutting off all communication with their home, and they have remained free from the disorder. Joseph himself died of heart disease; his wife, the mother of the seven children did not become a leper. Joseph Mora was an intimate friend of Andres, living close to him. He soon developed leprosy. Joaquin Guier, a friend of Mora, also contracted the disease. Some years later two friends of Joaquin Guier, living in the same house with him, also took it. Afterwards two sisters seem to have become infected through Guier, and in a short time their five brothers acquired leprosy. Of late years quite a large number of people in the village of Parcent have become lepers, without there being any other apparent means of infection than that above given. Since 1850 there have been in this little village about sixty cases of leprosy, forty-five of which have proved fatal.

**Tubercular Inoculation.**—DR. E. V. DURING reports a case of inoculation of tubercle which came under his observation in Dr. Unna's Clinic in Hamburg. He lays down the following conditions to be observed before attributing any case of tuberculosis to a direct inoculation: (1) That the patient had not tuberculosis in some other part of the body at the supposed time of inoculation. (2) That an inoculation of tuberculous matter really took place on the reception of the trauma. (3) And that from the point of inoculation a tuberculosis developed. All three of these conditions are fulfilled in the following case: A healthy young girl with no previous history of tuberculosis either in herself or family, had assiduously attended a friend who died of tuberculosis pulmonum. Shortly after her friend's death she removed her ear-rings, and inserted them into her own ears. The girl said that her dead friend had frequently suffered from suppuration and slight hemorrhage from the perforations in her ears. Previous to her friend's death she herself had never worn ear-rings, although she had had her ears pierced some time before. In a very short time the ear-rings made the ears raw, but she still persisted in wearing them, although they suppurated profusely. When she came to the clinic the holes in her ears would not heal, there was an ulcer on her neck, and the patient suffered from a bad cough; she was pale and thin, but had a well-devoloped body. There was a shallow ulcer at the ear-ring hole of the left ear, which had undermined edges and an unhealthy appearance. There was a hard lymphatic gland on the left side of the neck, over which the skin was immovable. The skin over the gland had ulcerated, and the ulcer was covered with a dirty scab; it had irregular edges, and after removing the scab it secreted a thin fluid. There was dullness over the left apex, reaching below the clavicle, and some *râles* were heard in this situation. The sputum, and the granulations from the ulcers contained tubercle bacilli. The lobe of the left ear was split from above downwards so as to lay open the ear-ring perforation, then all the local affections on the ears and neck were freely cauterized, and dressings of oxide of zinc and ichthyol plaster mulls were applied, under which they healed in a short time. The patient is now rapidly going down hill, being in the last stages of phthisis, with profuse night sweats, diarrhea, evening rise of temperature, and implication of both lungs.—*Monat. f. Prac. Dermatol.*, No. 22, 1888.

**Syphilis and Smegma Bacilli.**—JULIAN MARKUSE has taken up the difficult task of determining the relationship between Lustgarten's syphilitic bacillus and syphilis. His results show that for practical purposes, at any rate, we cannot make use of either the presence or absence of this bacillus for diagnostic purposes. It was not constantly present in lesions undoubtedly syphilitic, while it was met with in non-syphilitic lesions; and furthermore a bacillus was found in the normal smegma of the glans penis, which could *not* be differentiated with any certainty from the so-called syphilitic bacillus.—*Vierteljahrsschrift f. Dermatologie und Syphilis*, Hft. 3, 1888.

**Treatment of Erysipelas.**—DR. NOLTE, starting with the proposition that erysipelas is caused by microörganisms (erysipelas cocci) as shown by Fehleisen, says that it should accordingly be treated with antiseptics, and that we should use those which are proven to be most effective against erysipelas cocci, namely, sublimate and carbolic acid. These may be applied to the parts affected by means of thick surgical dressings, but such dressings are at times very irksome to the patient, and are also expensive. To overcome these defects the author has used with excellent results a solution of carbolic acid (3 to 5 per cent.) in mucilage of gum arabic. This is painted over the affected parts twice daily.—*Allgemeine medicinische Zeitung*, December 15th, 1888.

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## MATERIA MEDICA AND THERAPEUTICS.

By WM. WATT KERR, M. A., M. B., C. M., Professor of Clinical Medicine, University of California, San Francisco.

**Strophanthus.**—At a meeting of the Académie de Médicine, DR. GERMAIN SEE reported his experience with the use of strophanthus in cardiac affections. In mitral stenosis the results were particularly gratifying, less so in aortic regurgitation. The pulse gained in strength, and the irregularities disappeared, but there did not appear to be any great tendency to an increase in diuresis. In all dilatations and fibroid hypertrophies dependent upon general sclerosis of the arteries the same results were obtained. In the painful affections of the heart and cardiac neuralgias the administration of strophanthus appeared to aggravate the malady. There was, however, no gastric disturbance, though at times the patient would complain of slight vertigo. DR. J. Y. DALE, of Lemont, Pa., claims to have experienced good results from strophanthus in the treatment of the excited cardiac action associated with exophthalmic goitre, and also in the palpitation which so frequently occurs during convalescence from the continued fevers.—*Medical Age*, Dec, 15 and 29.

**Erythrophlœin.**—As the result of some experiments made by DR. HERMANN, and reported in a recent number of the *Wiener klinische Wochenschrift*, the following summary may be made regarding the action of erythrophlœin in cardiac disease. The drug has a marked retarding influence on the heart, but the effect is not lasting. This is also true of its diuretic influence. The drug is well borne, and may be tried in cases in which digitalis, strophanthus, and similar medicaments are either not well tolerated or are contraindicated. Erythrophlœin does not appear to have any cumulative effect.—*Journal American Medical Association*, Dec. 29, 1888.

**Digitalis in the Treatment of Pneumonia.**—In this disease digitalis acts on the factor of fever, which in pneumonia is often the most prominent symptom. It also circumscribes the area of disease in the lungs, but the main indications for its use are to be found in the constitutional disturbance. In an uncomplicated case of pneumonia, it should be given whenever the pulse exceeds one hundred, irrespective of the extent of the pulmonary lesion. It should be borne in mind that in fatal cases death supervenes between the eighth and tenth day, and digitalis attains its maximum effect from the seventh to the tenth day. It is therefore necessary to prescribe the drug not later than the third day.—*Cincinnati Lancet-Clinic.*

**Antifebrin in Sciatica.**—DR. AUSTIN FLINT furnishes the *Medical Record*, of Dec. 1, 1888, the notes of a case of sciatica treated by him at Bellevue Hospital. The pain had been so severe as to confine the patient to bed for three weeks, during which time he had been treated by means of blistering, electricity, nerve stretching and a variety of internal remedies without experiencing any relief. Antifebrin was then used in as large doses as the patient could tolerate, fifty grains being given in four hours, with the result that the pain was nearly, but not entirely removed. The patient became somewhat cyanotic, and a half ounce of whiskey was given with the last dose. The next day the antifebrin was repeated in the following doses: 10 A. M., 20 grains; 12 M., 20 grains; making 40 grains in two hours. It was not necessary to give whiskey. The result was eminently satisfactory, for on the following day the pain was completely relieved, so that the patient could walk about the ward, and two days later he insisted upon leaving hospital. He promised to report if the pain should return, but though two and a half months had elapsed up to the time of Dr. Flint's report, nothing had been heard of the patient.

**Pyrodine.**—Pyrodine is another antipyretic obtained from coal tar, the properties of which have been investigated by DR. R. WILD, of Owen's College, Manchester. It is said to possess a far more powerful effect than any of its predecessors in reducing febrile temperatures. Toxic effects resembling aniline poisoning were observed on several occasions, and these appeared to occur more frequently in typhoid fever and acute rheumatism. The skin becomes jaundiced, and the reaction of aniline can be obtained from the urine. It is best adapted to cases of pneumonia, typhus and scarlet fever, and as it has to be given only once in eighteen hours, it is in this respect a convenient antipyretic. The dose is from two to four grains.

**Antifebrin in Headaches.**—DR. FISHER has observed the most satisfactory results in headache, and especially in neuralgia, from 10 to 20 grain doses of antifebrin. Relief was obtained in one-quarter to one-half hour. The patients who shortly before were in despair with the pain in the head, felt entirely relieved. This result was not obtained in cases where the headache was due to pathological change in the brain or meninges.—*American Journal of Medical Sciences*, Dec., 1888.

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## MEDICINE AND PATHOLOGY.

By ALBERT ABRAMS, M. D., Demonstrator of Pathology, Cooper Medical College, San Francisco, Cal.

**Pulsating Pleurisy.**—Forty-two cases of this extremely rare condition have been collected. It is almost invariably met with on the left side. In only three instances was the fluid on the right side. Empyema existed in all the cases, with the exception of one, in which the fluid was serous. There was pyopneumothorax in five cases. Two groups may be recognized. (1) The intra-pleural pulsating pleurisy. (2) The pulsating empyema incessitatis, in which there is an external pulsating tumor. The latter condition occurred in twenty-five of the forty-two cases. The external tumor is usually single, but in five cases there were two, and in one case, three tumors. The perforation of the pleura usually occurs on the anterior aspect of the chest, from the second to the sixth rib, sometimes close to the sternum. In three cases the tumor appeared posteriorly at the spine, at the angle of the scapula, and in the lumbar region. The pulsation in the intra-pleural cases is usually in the antero-lateral region of the affected side, and is only evident on palpation. Pulsating pleurisy usually occurs in cases where the fluid has existed for some time. Various explanations of the phenomenon have been offered. Broadbent believed it to be due to adhesions between the layers of the pericardium, and between the pericardium and chest wall, but this explanation can not hold good for those cases, which showed the non-existence of adhesions at the autopsy. Traube regarded destruction of the costal pleura and paresis of the intercostal muscles as the conditions necessary for its occurrence. Bouveret, in a recent monograph, maintains that the pulsation is met with wherever the resistance of the thoracic wall is greatly reduced, or when the resistance on the part of the diaphragm is heightened, as by a deposition of a thick layer of fibrin. A certain degree of pressure is necessary, inasmuch as the pulsation will at once cease, when only a small quantity of fluid is removed. Comby believes that the pulsation only occurs when the lung is compressed, and adherent to the pericardium, thus allowing the cardiac movements to be communicated to the thoracic wall. Cases of pulsating pleurisy have been mistaken for aneurism, and the situation where the pulsation usually develops, renders the error pardonable. A fine hypodermic needle will readily make the differential diagnosis. The prognosis of this affection is not very favorable. Of the thirty-eight cases collected by Kepler, seventeen died. It must be remembered that most of these cases occurred before the days of safe operations upon the chest wall. Complete evacuation of the fluid with free and permanent drainage, meets the indications for treatment.—PROF. OSLER, in the *American Journal of Medical Sciences*, Jan., 1889.

**The Pulmonary Artery in Anemia.**—PATELLA (*Annal. Univ. di Med. è Chir. Milano.* 1888), has studied the physical phenomena occurring in the pulmonary artery in healthy as well as affected subjects. An important symptom in anemia is the systolic murmur heard over the pulmonary artery. To this symptom must be added another which occurs, according to this author, in the majority of cases. It is a marked dilatation of the pulmonary artery with visible pulsation at a point corresponding to its situation on the chest wall. The dilatation can be determined by percussion. On palpation an impulse due to the expansion of the vessel is detected, as well as the closure of the semilunar valves, corresponding to the second pulmonary sound. The dilatation of the artery and the cause of the systolic murmur, is an angioparalytic condition of the artery. This murmur is the most constant of all the cardiovascular murmurs occurring in anemia.—*Centralblatt f. klin. Medicin*, Dec. 22, 1888.

**Inconstancy of the Diastolic Murmur in Aortic Insufficiency.**—DR. DEHIO agrees in the main with the interesting researches made by Timofejen, with regard to the acoustic phenomena observed in experimentally induced cases of aortic regurgitation. The conclusions of the latter author were: (1) Every case of aortic insufficiency is not necessarily followed by a diastolic murmur, and only then occurs when the valvular defect is sufficiently pronounced. (2) That when the valvular defect is not pronounced, only an accentuation of the second aortic sound is noted. (3) That the diastolic murmurs in relatively small defects, disappear when the arterial blood pressure is reduced; in large defects only, will a diminution of the blood pressure fail to influence the murmur. These experimental facts have been corroborated by clinical observation. Dehio explains the occasional absence of the diastolic murmur in diminished blood pressure, as follows: The stronger the blood pressure in the beginning of the aorta at the ventricular contraction, the more forcible will be the blood pressure against the closed aortic valves after subsidence of the heart's systole. If a defect in the valve exists, then the blood returning to the ventricle will be forced through at a greater pressure, leading to a loud diastolic murmur, which must be louder in direct proportion, as the initial or positive pressure in the aorta is increased. In larger defects, which allow of an increased regurgitation, differences in the positive pressure can have no material influence on the intensity of the murmur. In small defects, a strong positive pressure is necessary for the production of a murmur.—*St. Petersburger medicin. Wochenschr.*, Dec. 22, 1888.

**Asthma—Its Cause and Treatment.**—DR. BRUEGELMANN makes the following divisions of asthma: (1) Nasal asthma. (2) Pharyngo-laryngeal asthma. (3) Bronchial asthma. (4) Toxic asthma. (5) Neurasthenic asthma. Certain drugs have always enjoyed the reputation of being anti-asthmatic remedies. Stramonium is one of the oldest of these and is usually employed mixed with sal ammoniac, lighted, and the white irritating fumes inhaled. The latter mixture is indicated in the bronchial and toxic forms, and is useless in nasal and pharyngeal asthma. Iodide of potassium is employed under like conditions. In neurasthenic asthma, arsenic has been used with success, although useless in other forms. Cannabis Indica and pyridin will often disappoint. Nitrite of amyl is often of value in bronchial and toxic asthma. Cocaine assists in the treatment of the neurasthenic forms, but should be employed with great caution. Morphine subcutaneously is indicated in all forms, and is invaluable. The same may be said of chloral hydrate. The employment of the faradic current is only indicated in the bronchial and toxic forms of asthma and is employed as follows: One pole to the vagus the other to the nose, in the pharynx, on the breast, or both poles over the larynx, according to the situation of the affection. The sitting lasts from fifteen to twenty minutes; and the effects are often magical. All the foregoing agents are merely palliative, and each case requires special treatment.—*Therapeutische Monatshefte*, January, 1889.

**Yellow Fever.**—DR. PAUL GIBIER recently read a paper before the New York Academy of Medicine on experimental researches connected with the etiology of this disease. It will be remembered that the French Government in September, 1888, commissioned him to go to Florida and study yellow fever, which was prevailing there at that time. On arriving at Jacksonville the epidemic had begun to decline, but he was able to see several cases of undoubted yellow fever. The theory which he supported is, that yellow fever is an intestinal affection, and, if true, it should be treated from the incipiency by remedies directed to the intestinal tract, and by the use of disinfectants, as bichloride of mercury, napthalin, etc. He cited two objections to this theory: (1) If yellow fever were an intestinal disease due to a microörganism, why was this not found in all cases after death? (2) If this cause were admitted, how could we explain the albuminuria present? In answer to the first question, Gibier stated that after a microörganism had saturated a culture-medium its growth stopped and, if then another microbe were introduced it would replace the former. So it might be in the fluids of the intestine in yellow fever. He would not be surprised to find his microbe in some cases only during the first days of the disease. The alterations in the other organs during the course of the disease might be accounted for by the ptomaines generated by the microbe which entered and poisoned the blood. The poisons seemed to be especially plentiful in the radicles of the vena porta. Albuminuria was not unusual in other affections, as typhoid fever, where the original lesion was in some other organ.—*Medical Record*, January 26, 1889.

**A New Method in Physical Diagnosis.**—DR. SEHRWALD calls attention to a new diagnostic method, which he designates as "Plegaphonia," and which serves as an efficient substitute for bronchophony, when the latter cannot be practised. Bronchophony, as is well known, signifies the auscultation of the voice over some part of the thorax. When, owing to laryngeal disease or from whatever cause, the vibration of the vocal cords is prevented, the bronchophony ceases to be a method of any diagnostic importance. After a series of experiments, Dr. Sehrwald finds that forcible percussion over the larynx will yield certain acoustic phenomena which may be utilized for purposes of diagnosis. He formulates the following conclusions: (1) In many affections an examination for the vocal fremitus or for bronchophony cannot be conducted owing to conditions which impair the voice. In such cases laryngeal percussion practised with the hammer and pleximiter will supplant the former methods. (2) The percussion tone of the larynx is almost exclusively conducted by the air in the bronchi to the thoracic wall, where it may be auscultated. (3) Over infiltrated lung tissue the sound has lost but little of its original character. (4) When a large portion of the lung is infiltrated, a change of the tone is produced in opening and closing the mouth. When the mouth is open the sound is more tympanitic. (5) Over healthy lung tissue, the sound is less loud, is not tympanitic in character and shows no difference whether the mouth be opened or closed. (6) Over an exudation the sound is weakened, and, by light percussion, absent. (7) Over cavities the sound is louder, and more tympanitic than over infiltrated lung tissue. (8) In pneumothorax the sound receives a metallic by-tone. (9) The intensity of the sound is greater on the side opposite the laryngeal half percussed, in deep inspiration and with the mouth closed. (10) Owing to the convenient position of the part percussed, the patient may, when occasion demands, practise percussion.—*Muenchener medicin. Wochenschrifi*, Jan. 1 and Jan. 8, 1889.

**The Pathological Conditions Following Severe Burns.**—DR. EUG. FRAENKEL has recently had an opportunity of investigating the pathological changes found in three persons, who had died after severe burns. The *post-mortem* examination often fails to yield satisfactory evidence of the cause of death in these cases. Numerous hypotheses have been advanced. Somenbury, who has written a monograph on this subject, attributes death after extensive burns either to cardiac paralysis following overheating of the blood, or to a condition of collapse, the result of excessive irritation of the nervous system. Ponfick attributes death to a destruction of the blood corpuscles, which yield their hemoglobine, which latter induces in vital organs parenchymatous degenerations. Lesser maintains that death is due to anemia (oligocythemia), caused by a destruction of the red blood corpuscles. These authors have supported their respecive views by experiments on animals. Fraenkel's investigations support the hypothesis of Ponfick. He found changes in the kidneys of a degenerative character, with obliteration of the uriniferous tubules by hemoglobine masses. These changes were also found in the liver and spleen. Owing to the rapid parenchymatous changes in the viscera, little can be done in the way of treatment.—*Deutsche medicin. Wochenschrift*, January 10, 1889.

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## MENTAL DISEASES AND MEDICAL JURISPRUDENCE.

By W. H. Mays, M. D.; Professor of Mental Diseases and Medical Jurisprudence, University of California, San Francisco.

**The Continuous Use of the Bromides.**—In epilepsy there is an abnormal or excessive generation of nerve force, a sudden activity of the gray matter in some portion of the brain and a rapid liberation of energy. The bromides lessen the susceptibility of the cerebral gray tissue and diminish reflex action. The continued use of the bromides, like other alkalies, increases tissue waste. During their administration we must, therefore, guard against emaciation by enforcing a liberal, easily digested diet, and the administration of cod liver oil. Cases of epilepsy are met with, in which the cessation of the convulsive attacks is followed by mental disturbance. This mental disturbance has been regarded as due to the medicine taken—an erroneous view. The use of the bromides should not be abandoned when mental aberration follows the cessation of the convulsive seizures. In these cases the brain has become accustomed to excessive discharges of nerve force, which have heretofore taken the shape of muscular convulsions, but when this tendency is controlled by treatment, the discharge becomes mental rather than motor; there ensues a convulsion of ideas rather than a convulsion of muscles. The anti-epileptic treatment should be continued, with the addition of cod-liver oil, phosphorous and other nerve tonics.—Dr. Baker *in the Medical Register*.

**Music as a Sedative in Insanity.**—The old notion that music may be utilized as a therepeutic agent in mental disorders is revamped in the *Albany Medical Annals*. While there is not much music in medicine, there may be medicine in music, says that journal. The testimony of Dr. Rush is adduced, who, in his work on the "Mind," published in 1825, says: "I attended a patient who told me that one of his paroxysms was cured by hearing 'Old Hundred' sung in church." Again, he says: "Music in hypochondriasis has often afforded great relief." Other writers are quoted to show the power of music over insane persons. [The idea that music exerts a soothing influence over the insane is merely an instance of the longevity of a popular superstition. Like the belief in the moon's influence, it dies hard. The quotations from Dr. Rush are not very conclusive. That most lugubrious air "Old Hundred," has probably caused more paroxysms than it has cured. I found that when the Asylum Band was playing near the female department at the Stockton Asylum, the inmates invariably became excited and demonstrative. Habitually quiet patients began to be restless and disturbed, while the more acute cases became absolutely uproarious. While the band would be discoursing its choicest strains outside, the wards within would be in an unwonted state of commotion. It may be urged that there are two kinds of music, the real and the so-called; but as far as my observation goes, the quality of the articles makes no difference in its effect upon patients. When Music, heavenly maid, was young, she was credited with remarkable powers; she inspired rocks and trees to dance; she lured serpents from their holes and dragons from their lairs; she soothed the savage breast; she lulled the frenzied maniac into peaceful slumber. She does such wonders no longer in these degenerate days.—W. H. M.]

**While There's Life There's Hope.**—After a man has been four years an inmate of an asylum, his chances of recovery are generally considered to have receded to a vanishing point. DR. POPE, however, shows in the *Journal of Mental Science* that recovery from chronic insanity, though rare, is not so exceptional as is usually supposed. He gives an account of eighteen cases, in some of which recovery took place after eight, nine and ten years. Some of these cases have been under his observation for a long period subsequent to discharge, and recovery seems undoubtedly permanent. [An instance was related to me by the venerable DR. SHURTLEFF, occurring during his management of the Stockton asylum, in which a patient recovered completely and permanently who had been insane for twelve years.—W. H. M.]

**Insanity from Hasheesh Smoking.**—This is the most frequent cause of lunacy in Egypt. Of 226 men in the Cairo Lunatic Asylum, 173 were there from dissipation with the drug. Early cases arrive very excited, with exalted ideas, but before the end of a year they usually join the ranks of chronic dementia. Hasheesh (cannabis Indica) was introduced into Egypt about 1232. In 1378 the drug was so abused in Cairo that the Emir destroyed all the hasheesh he would find and punished the consumers by extracting their teeth. It produces weakmindedness, chronic insanity and death. Hasheesh devotees are recognized by dilated pupils, increased appetite, irritability of digestion, diarrhea, falling of eye lids, debility, anemia, and ever increasing timidity. This latter symptom is sometimes strikingly marked.—F. M. SANDWITH, in *Journal of Mental Science*.

**The Use of Restraint in Asylums.**—At a meeting of the Medico-Psychological Association, at Edinburgh (*Journal of Mental Science*), this question was discussed, the drift of opinion favoring a moderate amount of restraint as more humane than entire non-restraint. DR. YELLOWLEES mentioned the case of a patient who was held down by two attendants, night and day, because he was determined to destroy his eyes. He urged to the superintendent that it was at once kinder and safer to fasten the man's hands. The superintendent replied that he had never used restraint, and never would. The result was that in spite of constant watching, the man succeeded in destroying both his eyes. Restraint is justifiable: (1) In cases where the suicidal tendency is intensely strong, leather gloves should be put on these patients without hesitation, for their own protection. (2) In cases of violent and furious mania. (3) In extremely destructive and restless patients. These patients must be kept still if we are to save their lives. The alternative to mechanical restraint is manual restraint, the patient being held by attendants; which is neither so constant, so effectual nor so safe. DR. URQUHART said that there were individual cases where restraint was as necessary as a splint to the broken leg of a child. DR. RUTHERFORD thought there were times when mechanical restraint was required, but the principle was deleterious and liable to abuse, and that they should do without it as far as possible. DR. CLOUSTON said that we have now passed into a more scientific era, and were free from the passions and prejudices of Connolly's great struggle. They must all agree with most of Dr. Yellowlees' general principles. A physician with any self respect must claim liberty to use any means he may think fit to prevent the death and promote the recovery of his patient. In extremely violent cases he would commonly apply seclusion rather than restraint. In less violent cases, hard work in the fresh air was better, as it provided a physiological outlet for the excessive motor energy of the cortex. Restraint was liable to abuse, and therefore ought to be used with caution. It irritated some people very much indeed. There are cases, however, where restraint is the only remedy; the most humane resource, the most scientific application of the principles of modern brain therapeutics. If, by it, we could really conserve energy or save life in any case, he would be deeply blameworthy who did not use it.

**A Few Therapeutic Suggestions.**—Chiefly from DR. MANN.

*Puerperal Mania.*—10 grs. calomel, followed by a saline; then camphor monobromide, grs. 4, in capsule.

*Hysterical Mania.*—A pill of belladonna, introduced into os uteri.

*Nymphomania.*—4 grs. camphor monobromide after a cathartic.

*General Paralysis of the Insane.—Sedative pill.*

℞—Zinci Valerianat., ʒi.
Ext. Belladonnæ, gr. ii.
M.—Et fiat pil., No. 30. Sig.—A pill every two hours.

*Tearing off Clothing* (Hyperesthesia of Body).—Camphor monobromide, 4 grs., ter. die.

In great motor excitement, fl. ext. conium, in half-dram doses produces quiet, and muscular relaxation. In great depression and melancholy, warm baths and gradually increasing doses hydrochlorate of morphine will antagonize the morbid pyschic state. Fluid extract of ergot is the antagonist to states of recurrent mania with lucid intervals; combine it with bromides and digitalis. In acute mania with much restlessness, envelop the whole person in a sheet wrung out of hot mustard water; put him to bed, and dry-cup the back of the neck. Iron, phosphorus, zinc and strychnine counteract cerebral degeneration. Give Cannabis Indica in hallucination with excitement. Full feeding means tranquility.

**The Hopelessness of the Morphine Habit.**—Whatever we may do short of rigid physical restraint, we are powerless to arrest the morphine habit when once it has taken thorough hold. It is more tenacious than the alcoholic habit, bad as that is. Few physicians have seen a larger number of morphine habitués than I have. They have come to me from all parts of the world, and from all professions. In the presence of this experience, extending over many years, I have never yet known an instance in which I could be quite sure the fully confirmed habit has been absolutely or permanently abandoned. I may have heard of such cases; I have seen none. Sometimes a patient has come to me, and under urgent advice has abstained resolutely for a time, but after a longer or shorter period there has been a relapse and a steady return to the habit.—DR. B. W. RICHARDSON in the *Asclepiad.*

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## PUBLIC HEALTH.

By W. R. CLUNESS, M.A., M.D., Sacramento, Cal.

**Mortality.**—The deaths registered in 75 town districts of the State during the past month, in a population of 773,000, correspond to an annual rate of 15.53 a thousand, the total mortality reported having been just 1000. 115 deaths were due to zymotic diseases, giving an annual rate of 1.78 a thousand. Of these 45 were due to diphtheria, 3 to typhoid fever, 2 to typho-malarial fever (so called), 3 to remittent fever, 11 to cerebro-spinal fever, 7 to whooping cough, 1 to scarlet fever, 3 to small-pox, 7 to diarrhea and dysentery, and 6 to cholera infantum. 306 deaths resulted from diseases of the respiratory organs, giving an annual rate of 4.75 a thousand. Of these 167 were due to consumption, 105 to pneumonia, 34 to acute bronchitis, and 12 to pulmonary congestion; the rates being for consumption and pneumonia respectively 2.56 and 1.63. The average annual death rate from all causes, occurring in the ten largest cities and towns in the State, and representing a population of 593,000, was 15.44. The highest rate for the month, occurring in cities having a population of 10,000 or more inhabitants, was reported from Pasadena, Los Angeles County, the rate having been 27.60 a thousand; the lowest was attributed to Chico, the rate having been but 4.80.

**Small-Pox.**—Although but three deaths from small-pox have been reported for the past month, yet there is undoubtedly present such an atmospheric condition as requires but little intensification to cause its spread, provided the utmost precaution be not maintained in the isolation of those who may become attacked, and the revaccination of those who are not fully protected. And it is seldom that so many foci of this disease have been reported in a single season throughout the whole continent as at present. When, therefore, we have at our command a prophylactic in vaccine virus which is so universally regarded as being nearly absolute, and, when applied with due care, so utterly harmless, it would appear that there can be no valid reason for the general prevalence at any time of the disease in question. Our own conviction is that the blame should mainly be attached to the medical fraternity, for it is believed to be the duty of each member thereof to *know* that all of his patrons, at least, are repeatedly and thoroughly vaccinated. There is, however, a very large floating element, which has no claims upon any physician, and it is often observed that the first cases occur amongst them; yet, if all others were thoroughly protected, the danger of the general spread of small-pox would be reduced to the minimum. But while three deaths only resulted from small-pox, forty-five were due to diphtheria, yet the public is but little more alarmed in consequence thereof than it is because of the hundred and five deaths resulting from pneumonia, although it is also a highly contagious and probably a more fatal disease. It is also an equally loathsome disease in many respects, and is far more likely to be followed by dangerous sequelæ. Then, why the terror of the former and the criminal apathy regarding the latter disease, whose victims are usually one hundred times more numerous? Simply because the public *knows* small-pox to be highly contagious, and has not been educated, as it should be by physicians generally, regarding the contagiousness of diphtheria. Medical men are everywhere the conservators of the public health, and it is equally incumbent upon them to prevent as to cure disease. They should, in reference to diphtheria, especially, impress upon the public the fact that it manifests a wonderful tendency to cling to a locality in which it has once appeared, notwithstanding the most rigid sanitary precautions. Hence the necessity for the most thorough disinfection of every portion of apartments, including the floors, after each case.

## METEOROLOGY.

By J. W. ROBERTSON, B.A., M.D., Assistant Physician to the State Asylum for Insane, Napa, Cal.

**Monthly Bulletin Signal Service (U. S. A.) for December.**—*Weather:* Fair weather has prevailed during the month to an unusual extent along the entire Pacific Coast. Rain fell at irregular intervals in Oregon and Washington Territory until the 24th of the month, being followed by an entire week of clear weather. In California, rain fell as follows: In Northern California, on the 3d, 4th, 10th, 11th, 12th, 17th, 20th and 21st. In Southern California, on the 5th, 12th, 13th, 14th, 15th and 16th.

*Temperature.*—The mean temperature of the month has been about normal in all districts, being slightly higher than usual along the immediate coast, and slightly lower than usual over the interior. Mean temperatures at selected stations are as follows: Portland, Or., 39; Roseburg, Or., 41; Red Bluff, Cal., 46; Sacramento, Cal., 45; San Francisco, Cal., 49; Fresno, Cal., 44; Los Angeles, Cal., 51; and San Diego, Cal., 52 degrees.

*Rainfall.*—The rainfall has been less than usual in all districts; markedly so, except in the extreme southern portion of California, where it is very nearly normal.

## California—Tabular Statement for January, 1889.

| STATIONS. | | TEMPERATURE. | | | | | | RAINFALL. | | Mean Relative Humidity ........ | WEATHER. | | | WIND. | FURNISHED BY— |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Mean.......... | Highest ........ | Lowest........ | Mean Highest........ | Mean Lowest......... | Mean Daily Range ........ | No. of Days Rain Fell.... | Total Rainfall........ | | No. of Clear Days...... | No. of Fair Days...... | No. of Cloudy Days........ | Prevailing Direction. | |
| Auburn .......... | Cal. | 44.6 | 64.0 | 27.0 | ........ | ........ | ........ | ...... | 0.33 | ........ | ...... | ...... | ...... | W. | Southern Pacific Co. |
| Berkeley ....... | “ | 47.4 | 60.0 | 35.5 | 55.3 | 42.3 | 9.3 | 5 | 0.78 | 82.5 | 22 | ...... | 9 | N&NNE | Obs. Univ. of Cal. |
| Colfax........... | “ | 43.2 | 64.0 | 28.0 | ........ | ........ | ........ | ...... | 0.50 | ........ | ...... | ...... | ...... | N. | Southern Pacific Co. |
| Eureka.......... | “ | 48.0 | 71.0 | 29.0 | 55.1 | 38.7 | 16.5 | 13 | 4.25 | 79.5 | 13 | 9 | 9 | N. | Signal Service U.S.A. |
| Fresno.......... | “ | 43.6 | 63.1 | 28.0 | 53.0 | 34.5 | 18.5 | 2 | 0.34 | 85.6 | 16 | 5 | 10 | N. W. | “ “ “ |
| Keeler. ......... | “ | ........ | ........ | ........ | ........ | ........ | ........ | ...... | ...... | ........ | ...... | ...... | ...... | ........ | “ “ “ |
| Los Angeles.... | “ | 54.2 | 71.0 | 32.0 | 63.4 | 41.5 | 21.8 | 4 | 0.25 | 59.4 | 19 | 6 | 6 | W. | “ “ “ |
| Monterey ....... | “ | 49.8 | 70.0 | 29.0 | ........ | ........ | ........ | ...... | 0.81 | ........ | ...... | ...... | ...... | SE. | Southern Pacific Co. |
| Napa............ | “ | 41.6 | 56.0 | 30.0 | 48.9 | 34.3 | 14.5 | 4 | 1.82 | ........ | 22 | 6 | 3 | N. | Sta. Napa Ins. Asylum |
| Oakland ........ | “ | 47.68 | 62.0 | 34.0 | 53.0 | 42.16 | 13.29 | 7 | 0.90 | 86.2 | 20 | 6 | 5 | NE. & E. | J. B. Trembley, M.D. |
| Paso Robles.... | “ | 41.6 | 67.0 | 22.0 | ........ | ........ | ........ | ...... | 0.78 | ........ | ...... | ...... | ...... | S. | Southern Pacific Co. |
| Red Bluff....... | “ | 45.8 | 68.0 | 30.0 | 54.8 | 35.1 | 19.7 | 7 | 0.51 | 67.4 | 17 | 5 | 9 | N. | Signal Service U.S.A. |
| Sacramento. ... | “ | 44.6 | 62.5 | 31.0 | 53.6 | 35.8 | 17.8 | 3 | 0.15 | 78.2 | 18 | 9 | 4 | NW. | “ “ “ |
| San Diego....... | “ | 51.6 | 77.8 | 36.5 | 66.9 | 42.8 | 24.1 | 5 | 1.72 | 79.0 | 19 | 4 | 8 | NW. | “ “ “ |
| San Francisco.. | “ | 49.2 | 64.0 | 40.0 | 56.5 | 44.3 | 12.2 | 7 | 1.28 | 75.8 | 13 | 13 | 5 | N. | “ “ “ |
| Santa Barbara.. | “ | 53.0 | 68.0 | 38.0 | 58.0 | 48.8 | ........ | 3 | 0.29 | 66.0 | 24 | 3 | 4 | W. | Hugh D. Vail. |
| Santa Cruz...... | “ | 50.9 | 70.0 | 34.0 | ........ | ........ | ........ | ...... | 0.99 | ........ | ...... | ...... | ...... | S. | Southern Pacific Co. |
| Yuma........... | A. T. | 53.0 | 71.6 | 35.1 | 63.9 | 42.8 | 21.1 | 2 | 1.12 | 52.4 | 22 | 3 | 6 | N. | Signal Service U.S.A. |

Blank (......) indicates data missing.

CLEAR DAY—One on which cloudiness is 3 or less on a scale of 10. FAIR DAY—One on which cloudiness is from 3 to 7.

CLOUDY DAY—One on which cloudiness is over 7.

# Occidental Medical Times.

JAMES H. PARKINSON, L. R. C. S. I., EDITOR.

**COMMUNICATIONS are invited from all parts of the world. When necessary to elucidate the text, illustrations will be furnished without cost to the author.**

SACRAMENTO: MARCH, 1889.

## THE LEGISLATURE.

The twenty-eighth session of the Legislature is rapidly nearing its constitutional limit, and several important measures in relation to the profession have not yet been passed. The following is the present condition of those measures to which we alluded in our last issue.

Of the bills in relation to seduction, Senate Bill 70 has been passed, and has been read a first time in the Assembly. Senate Bill 69 has also passed and is on file in the House. Assembly Bill 220 has been withdrawn in favor of Senate Bill 68, which is of the same tenor, and has passed the Senate; and has been read a first time in the House. Senate Bill 150, relating to rape, has been read a first time, Senate Bill 153, relating to the commitment of the insane, has been read a first time.

Senate Bill 190, providing for the establishment of a branch insane asylum at Ukiah has passed both houses and has been approved by the Governor. Assembly Bill 62, establishing a branch asylum in Southern California, has been amended by including the counties of Ventura and Santa Barbara, increasing the Commission to five members and raising the appropriation to $350,000 and passed; and has been read a first time in the Senate. A new measure, Senate Bill 377, provides for the establishment of a branch insane asylum within the county of Shasta, to be known as the Northern State Insane Asylum. The main objection to these bills is an economic one. The amount now required for the support of the three asylums is appalling, and the appropriation by this Legislature will probably be in the neighborhood of $1,500-000. The establishing of asylums in sparsely settled counties of the State is needless and extravagant, and cannot be urged upon any reasonable ground. With Southern California the case is not parallel. That section has grown and is growing rapidly in population, and the evils involved in a prolonged journey by the insane patient are therefore multiplied. The establishment of a small asylum either for temporary detention, as has been suggested, or as a permanent hospital, is a step in the right direction. Assembly Bills 102 and 103, relating to improvements at the Napa Asylum, have been passed, and are on their way through the Senate. Assembly Bill 186, relating to the government and management of the California Home for Feeble-minded Children, has been read a first time and has passed the Senate. Bill 187, providing for a permanent site, and for the erection of buildings for this purpose, has been withdrawn in favor of Senate Bill 194 of the same tenor which had been passed. There has been a good deal of opposition to the present site of the Home, but after a hard fight it has been retained in Santa Clara county. Assembly Bill 30, providing for a State Reformatory for juvenile criminals, and for a department for the criminal insane, has been withdrawn. Assembly Bill 135, relating to the probationary treatment of juvenile offenders, has been read a first time, and Bill 161, relating to the sale of intoxicating drinks to minors, is in the same condition. For Assembly Bill 23, relating to the hours of employment of minors, a substitute has been introduced and read a first time. Senate Bill 11, relating to the sanitary condition of factories and workshops and the preservation of the health of employés, has passed both houses and has been approved by the Governor.

Senate Bills 88, 89, 90, 91, 92, 93, 94 and 95, which were introduced at the instigation of the State Board of Health, in Senate and Assembly, are in the following position: Bill 88, relating to the appointment of Health Officers in towns of 500 or more inhabitants, has been withdrawn in favor of Assembly Bill 210, which has been passed. Bill 89 (combines Sections 3077 and 3084 Political Code), relating to the interment or cremation of human bodies has passed both houses. Bills 90 and 91, relating to the registration of births, deaths and marriages have been passed, and the latter has had a first reading in the Assembly. Bill 92, providing for a general vaccination, has been amended by exempting children proved to be insusceptible to vaccination, and permitting certain provisions to be carried out by persons other than physicians; and has passed both houses. Bill 93 (amending Section 377 Penal Code), relating to the disposal of dead human bodies, has been withdrawn in favor of Assembly Bill 216, already passed by the House. Bill 94 created the office of State Sanitary Inspector, and that of State Veterinarian. This bill had been withdrawn in favor of Senate Bill 128, which has since been withdrawn. We understand that the former bill has been amended, by cutting out the State Veterinarian, and reintroduced. A little reflection will show that this is a judicious measure. The State Board of Health is frequently called upon to make inspections, furnish advice, or decide the identity of doubtful cases in various localities. Hitherto this work has generally been performed by the Secretary of the Board. The salary of that officer is insufficient to compensate him for the additional labor. From force of circumstances and custom, this work has been performed within a limited radius around Sacramento, to the manifest disadvantage of other and more remote sections of the State which are equally entitled to this service. With the appointment of a Sanitary Inspector, the Board would be in a position to furnish such service when required, and could also order investigations when deemed proper. Senate Bill 95, appropriating $20,000 for the State Board of Health as an emergency fund, was amended by reducing the amount to $10,000. Assembly Bill 213, appropriating the original amount, which has passed the House, has now been substituted.

Senate Bill 127, regulating the practice of veterinary medicine and surgery in the State has been amended and read a second time. Assembly Bill 121, regulating the practice of pharmacy and sale of poisons has been read a first time. We can only repeat that this is a very desirable and necessary measure.

Of the new measures that have been introduced, Senate Bill 624 empowers coroners in cities of 100,000 or more inhabitants to appoint a stenographer (at a fixed salary) to take testimony at inquests; also a physician to make autopsies, at a salary of $200 a month. This bill at present can only apply to San Francisco. Referring to the last report of the San Francisco Health Department, we find that the number of autopsies made by the City Physician was 116, and as this work was done without extra compensation some relief from the imposition is clearly needed. The bill is in committee in both houses. Senate Bill 625 provides for the appointment of a state veterinary surgeon at a compensation of $3000 per annum and travelling expenses. This officer shall be appointed by, and shall be under control of, the State Board of Health, by which authority his duties shall be prescribed. The board can appoint two assistants, to be paid when actually in service. It will be noticed that this is simply a portion of Senate Bill 94, previously withdrawn, with the modification which we advised, that the state veterinarian be paid a fixed salary and not a *per diem*. Assembly Bill 301 provides an additional assistant physician for the Napa asylum at a salary of $2000 per annum. Bill 424, amongst other things, provides an additional assistant physician for the Stockton Asylum. Assembly Bill 411 makes it a misdemeanor to supply intoxicating liquor to any habitual or common drunkard as well as to Indians. Assembly Bill 417, to regulate the practice of veterinary medicine and surgery in the state, while a great improvement on Senate Bill 127, being practically similar to the present medical law, will, however, possess all the inherent weakness of the latter measure.

Assembly Bill 450 amends "An Act concerning actions for libel and slander," by including within its operations actions for alleged malpractice against physicians and surgeons. This act simply provides that in the case of these disgraceful and usually ungrounded persecutions, the same protection shall be guaranteed to the medical profession as is accorded to other citizens. We do not believe that the filing on the part of the plaintiff of a preliminary bond will stop these actions, but it may serve as a deterrant, and it will lessen the inevitable expense. Should this measure fail to pass during the present session we are certain that the matter only needs to be brought before the profession to secure a unanimous endorsement of its passage in the future. Assembly bill 488 adds a new section to the penal code prohibiting the use of acids in the manufacture of cans for canning purposes. Assembly Bill 565 appropriates $80,000 towards the construction of a college for the medical department of the University of California, the need for which is very apparent. Assembly Bill 582 adds a new section to the penal code, prohibiting the sale or use of opium for smoking. Assembly Bill 626 provides for the punishment of contractors for the burial of the indigent dead in case of specified breaches of contract and in case of the sale of any bodies for dissection. Assembly Bill 439 amends section 1510 of the penal code relating to coroners, by making the number of jurors six or twelve, and giving the coroner discretion, in cases of suicide, to hold, or not to hold, an inquest. Assembly Bill 564 allows a body to be exhumed for removal at the end of one year instead of two. Assembly Bill 616 virtually throws open the asylum for the chronic insane at Agnew's for the reception of all cases of insanity. Senate Bill 468 is the new medical law which was submitted to the State Medical Society at its last meeting. The bill, which was introduced at a late date, is still in committee, and there is no possibility of its passage during the present session. The Committee on Medical Legislation have not been unduly active in this connection.

## JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

That "all that glitters is not gold" has been exemplified by the course of the Trustees of the *Journal of the American Medical Association* in their selection of the recent editor of *The Journal.* The medical man chosen in November for this important position is a good surgeon, and a man of large political influence—which carries with it the outspoken enmity of many prominent medical men in the country. He was selected, presumably, on account of his high position and reputation—not as a writer, nor as an editor—but as an organizer and surgeon. *The Journal* was not in need of the services of a surgeon, and has been pretty well organized for several years.

Is it not about time that the Board of Trustees recognize that *The Journal* is a business venture, rather than a sentimental one? Does a business corporation select as its representative a man who knows nothing of the business? To edit a leading medical journal appearing every week, one requires special training, and the man with most training is best for a certain position, if with his training he can do good work. Age and grey hairs are not prerequisites for any place; but for an editorial position training and ability are essential. In selecting another editor it is to be hoped that the Trustees will profit by their recent unpleasant experience. No medical man in league with any clique should hold the position. Since the office of publication is in Chicago, the editor might, with advantage, be identified with the local profession. He should be a trained man; whether young or old, is of no consequence. The propositions that have come from certain quarters to remove *The Journal* to Washington, are absurd. There is not one good argument in favor of removing it from its present central position.

There has been a good deal said of late in regard to the desire to make the American Medical Association the greatest association, and its *Journal*, the greatest journal in the world. Nevertheless, it may be said that it will never arrive at the desired stage of greatness so long as it continues to tread on the toes of respectable members of the profession. Not a few times within two or three years *The Journal* has editorially sneered at everything pertaining to specialism in medicine, and quite recently—under the late editor—appeared an article that must have been unpleasant to members of the profession east of the Alleghany mountains. Are these opinions those of representative men in the American Medical Association? If so, do they hope to drive good men into the Association by abusing them and their work? If these opinions do not represent those of the broad-minded members of the Association, it would be well if some one were selected as editor who would not ventilate his private notions as official views. The Association, through its official organ, cannot afford to know an East and West, nor, so long as some of its best members are specialists, can it consistently carp at specialism. *The Journal* cannot abolish the special societies; the best it can do is to recognize specialism as an established fact. And perhaps when it utters opinions that are broader, and that are less offensive to large classes of men that are in the profession, the annual meetings will be better attended, the papers read will be better, and *The Journal* will be a great deal better.

## NOTES.

### Gazette de Gynecologie.

We have been informed that the publication of this journal has been suspended for the present, on account of the ill health of its editor, DR. P. MENIÈRE.

### Southern California Medical Society.

The Southern California Medical Society held its second semi-annual meeting at San Bernardino in December, 1888. A number of interesting papers presented appear in the *Southern California Practitioner* of February, '89. The society elected twenty-four new members, and is in a flourishing condition. The next meeting will be at San Diego on the first Wednesday in June.

### The Surgeon-General U. S. Marine Hospital Service.

DR. JOHN B. HAMILTON, after a brief incumbency as editor of the *Journal of the American Medical Association*, has resumed his duties as Surgeon-General of the Marine Hospital Service. A bill has been passed by Congress increasing the salary and making the tenure of the office for life. This measure has been pending for ten years, and it seems fair to assume that its passage at this juncture may be due in part to the ability of the present incumbent. As an organizer and director Dr. Hamilton has given many evidences of great capacity, and we trust that the country will for many years receive the benefit of his efficient services, and those of the department which he supervises.

### San Francisco Polyclinic.

A Polyclinic has been organized in San Francisco, and will be opened on or about March 1st. The object is charitable, medicine and advice being furnished to the sick poor gratuitously. A suitable location on Ellis street, near the Baldwin Hotel, has been procured, and is being fitted up for this purpose. The following well-known physicians comprise the medical staff: J. H. STALLARD, GEO. CHISMORE, J. D. ARNOLD, H. L. WAGNER, H. FERRER, M. REGENSBURGER, C. A. VON HOFFMANN, H. SHERMAN, ROBT. BOWIE, H. KREUTZMANN, A. P. WHITTELL. We trust that a post-graduate course will ultimately be included in the scope of the Polyclinic.

### Dr. F. C. Durant.

In the recent exposé in connection with the State Prisons, Dr. F. C. Durant, at present physician at San Quentin, and formerly located at Folsom, has come in for his share of the mud that has been flying freely. Charges of harsh treatment, rough language and neglect, have been made by several of the convicts. This is but a repetition of that which many a physician has experienced when in a public capacity, and the charges are of such a nature that it is impossible to disprove them as the acts invariably take place in the absence of a third person. Any one familiar with the hardened criminals to be met with in our prisons and jails, will realize how little credence can be placed in statements which they may be prompted to make. On the other hand, those who are acquainted with Dr. Durant will readily discredit accusations of conduct so foreign to the manner or nature of the maligned physician.

### Duration of Incubation and Contagiousness.

Ten years ago the Clinical Society of London appointed a committee to investigate the periods of incubation and contagiousness of the commoner communicable diseases. A certain amount of valuable material was received, but it was thought desirable to defer the presentation of a report until further experience was available. The society has now determined to gather additional information with a view to the preparation of an early report on the subject, and for this purpose has reconstituted the committee. The committee is desirous of obtaining particulars of cases which throw light upon the periods of incubation and contagiousness of the below mentioned diseases, and will be grateful for notes of any cases where the facts can be ascertained with sufficient precision to afford grounds for conclusions. It is thought that gentlemen practising at a distance from large centres of population, and especially those engaged in the public health service, or associated with schools, would be able to supply information of the kind required. A single case in which the dates of exposure to infection and the appearance of the first symptom can be accurately fixed, especially where the exposure has been limited in duration, would be highly valued. The following diseases are included within the scope of the inquiry: Variola, varicella, measles, German measles, scarlet fever, typhus, relapsing fever, whooping-cough, diphtheria, enteric fever, cholera, erysipelas, mumps, infectious sore throat. The committee consists of Dr. W. H. Broadbent, Dr. George Buchanan, Dr. Cayley, Dr. Thomas Barlow, Dr. Alfred Hill, Dr. Isambard Owen, Dr. Thorne Thorne, Dr. Adler Smith, and Mr. R. W. Parker, with Mr. Shirley Murphy, 41 Queen Anne street, and Dr. Dawson Williams, 25 Old Burlington street, W., as honorary secretaries, to one of whom communications should be addressed. Early reply would greatly facilitate the work of the committee.

### The Pacific Coast Vaccine Station.

The importance of maintaining a vaccine station on this coast, from which reliable virus shall be at all times obtainable is a question which the profession should carefully consider. The period during which the charged points in general use are considered active is about twenty-one days. It the physician procures his virus directly from the Eastern stations it will leave a period of fourteen days of activity. On the other hand, virus furnished by the local druggists may have been on hand for any period, and is consequently quite unreliable. Druggists realize this fact, and many of them refuse to carry it in stock. DR. H. A. DU BOIS, of San Rafael, being impressed with these facts, had, in 1868, made experimental inoculations on calves, and had used the virus thus obtained with success. He has devoted considerable attention to the matter during subsequent years, and in November, 1887, decided to propagate the virus on a more extended scale. After experimenting with different virus, Dr. Du Bois finally adopted that of H. A. Martin as the purest and the best. His subsequent experience was rather unfortunate, and we cannot but feel that the profession would have shown more judgment, if not friendly feeling, in encouraging an enterprise which could have been made mutually beneficial. Failures in vaccination are not an absolute criterion of the value of a particular virus, but angry arms, peculiar markings and obviously septic processes will stamp any vaccine as unreliable and dangerous. This has been amply demonstrated throughout the State during the recent epidemic. Our experience with Dr. Du Bois' virus was very limited, but, so far as it goes, was perfectly satisfactory. There seems to have been some misunderstanding between the Board of Health of San Francisco and the San Rafael station, and from the published report it would appear that much of this is chargeable to the vaccinators. Dr. Du Bois describes at some length the various processes adopted in the propagation of vaccine and very plainly demonstrates how and why the local effects of vaccination are sometimes disastrous, while the constitutional protection is absolutely *nil.* A perusal of the report will be instructive to every practising physician, and it will conclusively prove that the *best* virus is also the cheapest. Dr. Du Bois is keeping up his stock, but is not at present prepared to sell virus.

## SOCIETY PROCEEDINGS.

### SACRAMENTO SOCIETY FOR MEDICAL IMPROVEMENT.

*Regular Meeting, January 20, 1889.*

The President, J. R. LAINE, M. D., in the Chair.

**Resignation.**—The resignation of DR. G. G. TYRRELL was read and accepted.

**Dr. F. B. Sutliffe** read a paper on *Leprosy in Hawaii.*

**Dr. G. L. Simmons** said that, while in the course of his practice he had seen cases of leprosy, he had had no personal experience. He thought that the health authorities of the State should take every precaution to prevent the coming of lepers from Hawaii and the other localities in which the disease is endemic.

**Dr. W. E. Briggs** thought that the subject was sufficiently important to justify concerted action on the part of the various medical societies. The legislature should provide for the exclusion of leper immigrants, and for the eradication of the disease at present existing in this State.

**Dr. W. A. Briggs** said, with regard to the contagion of leprosy, that in vaccination we know that the results are frequently negative, even with the best virus. Immunity from all the contagious diseases is not rare. This will in a measure explain the apparent immunity of some subjects from leprosy. Every indication is in favor of leprosy being contagious. The subject was one that attacked the well being of society in general. He had seen the case mentioned this evening nine years ago. At that time there was merely contraction of the fingers. The great difficulty in the early recognition of leprosy was its slow development. Its symptoms are not pronounced or discoverable, and its contagious character is unquestionable.

**Dr. T. W. Huntington** had had no personal experience with leprosy. With regard to the connection between leprosy and syphilis, he had had a patient under treatment at the Railroad Hospital whose face and upper portion of body were covered with a bullous eruption. Being under the impression that the case might be of syphilitic origin, he placed the patient upon specific treatment, and the eruption disappeared, the case apparently recovering. He made a diagnosis of specific sycosis. He afterwards learned that the patient had been treated by Dr. Fitch, of San Francisco, who pronounced it a case of leprosy. Under specific treatment the case again recovered, which, in the speaker's opinion, seemed rather to exclude this idea.

**Dr. H. L. Nichols** had had some experience with leprosy years ago. The only drug he had found to be of any service was arsenic. In one case the symptoms had certainly subsided under its use.

The **President** mentioned a case that he had had under treatment in the Sacramento County Hospital nine years ago. The patient, an Englishman, had contracted the disease in India. At that time there was a knotted appearance of the brow, and on passing the hand over that region there was a distinctly nodular feel. He asked the patient if he did not think that he had leprosy. He said he supposed so, and he had noticed that on every ranch at which he had been employed the Chinese immediately left, and had refused to work while he was there. The patient subsequently died in San Francisco.

## SAN FRANCISCO COUNTY MEDICAL SOCIETY.

*Regular Meeting, January 8, 1889.*

The President, Geo. Chismore, M. D., in the Chair.

**Acute Mania, fatal, following Ovariotomy.**—Dr. H. Kreutzmann, reported a case of acute mania following ovariotomy which resulted fatally.

The patient was 46 years of age, and previous to her last illness had always enjoyed good health with the exception of some slight mental disturbance at the time of her confinement in 1884. In 1887 the tumor made its appearance and in June of the same year she was tapped with the result that half a gallon of fluid was removed. In September about five gallons were removed at a second tapping. The operation for removal of the tumor was finally undertaken. On section a multilocular cyst of the right ovary was found, and from one of the cysts the contents were oozing into the abdominal cavity through a hole left by the trocar which had been used in the former tapping already referred to; a fact that would indicate the danger attendant upon tapping abdominal cysts. The patient rallied well, the temperature being normal and the pulse 110, but this did not awaken much anxiety, as it had been her condition for months prior to the operation. On the sixth day she became restless and on the seventh night acute mania developed, the pulse and temperature remaining unchanged. It was supposed at first that the nervous excitement was due to iodoform intoxication, as a small quantity of that drug had been used in the external dressing, but no improvement followed its discontinuance and the patient died on the twelfth day. At the autopsy no signs of peritonitis were discovered, the liver was slightly atrophied, the spleen small and soft, and the kidneys presented the appearance of acute swelling and parenchymatous nephritis. At no time was albumin or iodine found in the urine although repeated examinations were made.

DR. W. H. MAYS, had listened with considerable interest to the paper as mania following such operations was somewhat rare. We all were aware that in patients suffering from chronic alcoholism any injury was likely to be followed by delirium or mania, and in others the same result frequently followed the prolonged use of an anesthetic especially if a predisposition to mental disturbance already existed. It was possible that in this case the iodoform contributed to the result.

DR. M. C. O'TOOLE, thought that as the mental disturbance did not commence until one week after the operation the effects of the anesthetic and iodoform would have passed away before that time.

DR. L. M. F. WANZER, suggested that it might have been the result of slow sepsis as was possible from the escape of the cyst contents into the abdominal cavity.

DR. H. M. SHERMAN, remarked that it might have been uremia although no albumin was found in the urine, and an examination might have shown a diminution in the amount of urea. The presence of nephritis as found at the autopsy would support this opinion..

DR. KREUTZMANN, replied that the iodoform was applied only to the skin. A similar case had been reported by a German physician who also believed that it was due to slow sepsis.

**Peculiar Vesical Formation.**—THE PRESIDENT exhibited a deposit which he had removed from the bladder of a man 40 years of age who had suffered from symptoms of stone, and had been repeatedly examined with negative results. In examining the bladder he found a foreign body which did not impart the sensation of a calculus when caught between the jaws of the lithotrite and evidently was not a stone. On washing out the bladder a number of small pieces of soft, slippery, brownish substance studded with triple phosphates were removed, a larger piece of the same substance being afterwards passed by the urethra. The patient has been completely relieved of his troublesome symptoms. Cocaine was use das a local anesthetic in the form of half a drachm of a 4 per cent. solution injected into the urethra, then one drachm into the bladder, which was repeated on the introduction of the instrument, additional quantities being added from time to time during the operation according to the pain, until about four ounces were used. In his experience this method has never produced any alarming symptoms, although much smaller quantities would be dangerous in the rectum owing to the difference in the absorbing powers of the two surfaces.

### *Regular Meeting January 22, 1889.*

The President, GEO. CHISMORE, M. D., in the Chair.

**Uremia.**—DR. J. H. STALLARD, read a paper on *Uremia*. In 1885, he had attended a patient who was suffering from stenosis of the pylorus due to maligant disease. He was rapidly emaciating, but had no signs whatever of any disease of the kidney. Eight days before death the urine was clear and acid, 25 oz. were passed in 24 hours, and the urea amounted to 420 grains. Seven days before death the urine was again examined, the quantity was 25 oz. and normal in appearance; it was acid, had no albumin, and the urea was 489 grains in 24 hours. On the fourth day before death the patient's stomach was quiet. He absorbed more liquid, the urine amounting to 30½ oz. the urea increased to 552 grains. In the evening a change began. The temperature, which had never exceeded 100° F., rose to 103° and to 105°, the pulse to 110°. The urine although not at first reduced in quantity, deposited a heavy cloud composed of immense quantities of epithelial casts, and albumin was present to the extent of 25 per thousand by Esbach's test; there was great exhaustion, inability to take food and hiccough. On the following day the amount of urine was reduced to 14 oz. and the urea to 100 grains in 24 hours. the cloud of casts now occupied one half of the vessel. Coma now supervened and death occurred three and a half days after the albuminuria commenced. Sections of the kidney show general cloudy swelling of the epithelium. The Malphigian tufts are greatly engorged, the straight tubes are seen, filled with casts not yet discharged. There are some extravasations into the connective tissue.

DR. SHIELDS asked Dr. Stallard what name he would give to the disease.

DR. STALLARD replied that the case differed in the symptoms from the ordinary case of acute nephritis in the very robust subject, but that in his opinion it was a case of parenchymatous nephritis.

DR. M. C. O'TOOLE, asked if Dr. Stallard, had made an ophthalmoscopic examination. In his experience albuminous deposits were at times discovered on the retina before its presence was shown in the urine. As an illustration he related a case that came to him from the country. The local practitioner had examined the urine and found that it was free from albumin; but, on ophthalmoscopic examination, the condition of the retina was very marked. The case had been referred to the late Dr. Kane, who upon examining the urine obtained albumin in small quantities.

THE PRESIDENT said that in his opinion this was a case of parenchymatous nephritis.

### *Special Meeting, January 20, 1889.*

The President, GEO. CHISMORE, M. D., in the Chair.

The meeting was called for the purpose of taking steps to procure legislation which would protect physicians and surgeons from unwarrantable malpractice suits.

DR. C. N. ELLINWOOD said that in view of the epidemic of malpractice suits, it had been deemed advisable that efforts should be made to have a law passed that would make such suits commence in a way similar to actions for libel or slander. In such cases, before suit is brought, the plaintiff must deposit $500.00 with two sureties, that in the event of the case being dismissed, or a judgment entered against the plaintiff, they will pay costs not exceeding this amount. It was desirable to amend this law so that it shall include actions of malpractice against physicians and surgeons.

**Dr. Jas. Simpson** thought that such an amendment was to be desired and could be obtained, but the time left during the present session of the Legislature was short, and it would require persistent effort on the part of a committee, some of whom should be continually on the ground to urge the matter.

**Dr. Ellinwood** moved the following resolution, which was adopted:

*Resolved*, That it is the sense of the San Francisco County Medical Society, that the passage of a law protecting physicians and surgeons from unwarranted suits for malpractice should be promoted.

**Dr. John Wagner** suggested that to escape special legislation the amendment might be made to include all actions for damages.

**Dr. M. M. Chipman** replied that there were no others who occupied the same position as physicians and surgeons. Furthermore, any general law would meet with greater opposition than an amendment such as had been suggested.

**Dr. J. D Rosenstirn** believed that such an amendment could not come under a law relative to libel, as no libels could begin until the charge of malpractice was proven false.

**Dr. R. Beverley Cole** thought that the amendment was both desirable and possible, but such a bill would not engineer itself through the legislature, and the only way to attain success was to appoint a committee who knew the methods best calculated to procure the passage of such a measure, and send them to Sacramento.

**Dr. Rosenstirn** moved that a committee be appointed to take legal advice in the matter and to report to the society at its next meeting.

**Dr. W. W. Kerr** moved as an amendment, that the chair appoint a committee with power to employ lawyers, and with instructions to carry the matter, as soon as possible, before the Legislature. The amendment was adopted.

**The President** then appointed the following committee: C. M. Ellinwood, C. G. Kenyon and E. R. Taylor, with power to add to their numbers.

## SPECIAL CORRESPONDENCE.

### Extracts from R. Virchow's Medical Recollections of a Journey to Egypt.*

The journey was made in company with D. Schlieman (of Trojan fame), who met the eminent professor at Alexandria—in February, 1888. After recording his observations on temperature, which during the journey were particularly careful and varied, he concluded as follows: They indicate how circumspectly the foreigner must arrange his mode of living, and how fallacious is the hope that for the invalid, steadiness or constancy of temperature can be depended upon. Chronic catarrh, and consumption is quite prevalent among the native population. Chronic bronchial catarrh was so usual that his medicine case, which contained some compound liquorice powder, quickly obtained celebrity. He also noticed that throat affections with glandular swelling were common among the ship's crew. The evening coolness made a warm overcoat at times quite necessary, while the noonday heat was often very uncomfortable. The most remarkable fact was the absence of sensible perspiration, even at the highest temperature. The climbing of the barren lime hills of Thebes in the glaring noonday sun did not produce sweating. It was only when the task was quite arduous—as in visits to the graves in the old Necropolis that perspiration began, and then quite profusely. His explanation of this apparent absence of sweating is that with the exceedingly dry air of Egypt, the outcoming moisture of the skin is quickly evaporated, leaving the surface as dry as before, and not as one might suppose, that the secreting action is arrested. This dryness of the air, which is also natural to the ground, is so great that rain scarcely ever falls in Upper Egypt or Nubia. So seldom that its occurrence is remembered and spoken of for years after. There are persons in Nubia who never saw rain. In the latitude of Cairo rain is more plentiful, and as this change has taken place since the days of Mahomet Ali, it is attributed to the plentiful planting of trees. In the neighboring bathing place of "Helwan," the new houses are built in a shadeless waste and tree planting is strictly prohibited.

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*Abstract and translation by G. L. Simmons, Jr.

The Egyptians, doubtless, congratulate themselves on the many sanitary advantages of a dry climate, for instance, the absence of malaria. Whoever undertakes a journey thither, well supplied with quinine, will return with an undiminished stock, malaria in Egypt being almost unknown.

The matter of drinking water is an important one. Although the Nile valley is rich in wells, they contain salt, which renders the water valueless. Sweet waters are so rare that those existing have enjoyed from the most ancient times, a great celebrity. The best known is the water of An or On, in the neighborhood of Heliopolis. In the citadel of Cairo is yet an old well, driven in the rock some 86 metres deep. It is called Joseph's well. This is surrounded by a winding stair, down which the visitors may go to the middle section of the well. The water is somewhat salty, but yet drinkable. Its first discovery is lost in the darkness of tradition. The larger cities have in more recent times established aqueduct systems, with filtration, namely Cairo, Alexandria and Assuit. They take the water from the Nile, and though it is not always as pure as might be desired, yet it has proved to be a useful drinking water. In the remainder of Egypt the people are dependent on water drawn directly from the river, at times subsequently filtered, but usually quite impure when used. Everywhere it is the duty of the wifely laborer to draw this water; a very arduous task, for the fluid is carried in heavy pitchers upon the head, at times a distance of from two to four miles. On a journey which will occupy some days, the traveller takes with him a Nile maiden who carries upon her head a small water pitcher.

Among those diseases attributable to the drinking water, infection with the "Distoma Hematobium," or, as it is now named in honor of its discoverer, "Bilhariza Hematobia," is the most formidable. Some maintain that the unfiltered Nile water is responsible; others the water standing in the wallows. Nothing certain is yet established, nor is its solution probable by the methods available. He has proposed to the Egyptian college to institute a thorough investigation on this point. The public estimation of the disease in recent times has been lowered. Fatal cases determined to be due to the bilharzia very seldom occur. Observations have shown that the action of the parasite on the human system has been grossly exaggerated. But it is correctly stated that in a moderate number of cases either the embryo or the bilharzia eggs can be found in the urine. It is also certain that whereas formerly the eggs were only known to exist in the mucous membrane of the bladder and rectum, their presence in other organs is quite possible. Dr. Kartulis, a very competent observer, has noted (*Virchow's Archiv.*, 1885, Bd. 99 S. 139) their occurrence in the kidneys, liver, prostate gland and pancreas, and beautiful specimens of these were shown. The same observer also exhibited lung preparations wherein the bilharzia were grouped and single.

The study of these pests deserves greater consideration, especially in reference to their life history. Several cases observed by Wortabet in Syria (*Virchow's Archiv.*, 1880, Bd. 91, S. 578.) go to prove that the propagation of the bilharzia is greater than might be expected. Domestic animals in the Delta are found to contain the pests and to act as a means of spreading the disease.

It is probable, he thinks, that the unclean drinking water is also responsible for the maintenance of that form of dysentery which prevails frequently and severely throughout Egypt. 92 per cent. of the mortality of Lower Egypt, in the week ending March 29, was due to this disease. The Anchylostomum, which he only briefly refers to, as its nature is correctly known through European observations, is disseminated by the drinking water, rendered impure from the admixture of fecal matter.

The Filaria Sanguinis, which is also common in Egypt, is directly spread by the drinking water.

Cairo is an especially infected point for enteric fever. The protection against this scourge, afforded by the sewers and canals of the city are very inadequate. Dr. Abbate Pascha (*Questions Hygieniques sur la ville du Caire Institut de Egyptien*) has fully shown the great advances in the sanitary improvement of the city, made under the last government, and has also pointed out how much more remains to be done. Drainage is very imperfect, the impurities being allowed to run into the cellars and gutters. Nor is a perfect sanitation probable while Egypt is as financially crippled as at present.

No one can dispute the fact that the pest that since the days of the Roman master has so frequently ravaged—Egypt, has, since 1844, disappeared from the land. The old opinion that it was an endemic sickness, a product of the Egyptian soil and life, has been proved by sufficient observation to be a very arbitrary conclusion. The cessation of the plague in Egypt corresponds in a remarkable manner with its disappearance in Syria and Arabia, from whence, in recent times, only isolated cases have been reported. Virchow believes that the sanitary arrangements are still very imperfect and insufficient to protect the people from the scourge which is yet liable to fall upon them.

Pruner holds the view that small-pox is a genuine African disease. Through him we also learn that scarlet fever and measles are seldom seen and have almost disappeared in the south. Concerning scarlet fever, Pruner says that for forty years it has occurred so very rarely that its existence is a matter of doubt. 1844 and '45 were the years when it was quite frequent. This has given rise to the argument which is difficult to refute, that Egypt is an unfavorable soil for this class of infectious disease. The "spotted fever" and relapsing fever were formerly regarded as one, and often designated "famine fever." It is to Dr. F. Engel (*Berlin. klin. Wochenschrift*, No. 17, 1884.) that we are indebted for demonstrating the presence of spirocheta in the blood of relapsing fever patients, and thus establishing its identity with the European disease of the same name.

With regard to the chronic infectious diseases, syphilis is so frequent that the Surgeon-General of the Egyptian Army declared to him that he regarded every chronic case as syphilitic until satisfied to the contrary. The disease exists in the cities, most commonly in the commercial centres. Among the country people of Nubia and Upper Egypt he saw nothing of the kind. The hospital at Cairo is a rich field for observing the manifold forms of this disease. Here, among others, he examined a Negress with large vitiligo spots, which frequently presented such distinctly stamped and scar-like appearances that the idea of a syphilitic basis also occurred to him. A patient in the hospital of the Cairo Medical School had brown spots on the face and neck, and between these, vitiligo, without elevation.

Two cases in Ballanye (Nubia) were an etiological mystery. One, an old man, with a scarred and increasing contraction of the anal orifice—almost a stenosis—the other, a woman of middle age, on whose cheeks and hands were great dark faded spots with lighter concretions, and accompanying scratches, ("Kabrus," he believes they call it). Yet the itch mite was not to be found, nor were there any visible marks of lepra discoverable.

Favus, within the scalp, is widely distributed among boys and men. Among the female sex he observed nothing of this nature. Large scabs were often seen on the scalps of small children. The men, even in the better classes, are not free from bald spots, which on the shorn or closely cropped head stand out boldly. The persistence and extent which the favus exhibits, is explained by this circumstance. The Egyptian and the Berberina, when at work, is entirely naked, except a short leather apron about the loins, and a thick, soft, and closely fitting cap on the head, which he rarely takes off. This cap, which is depicted in many paintings, on the old walls, is placed upon the head of the smallest child. It protects the shaven scalp from the rays of the sun, at least to a certain extent, but does not in the least hinder the growth and spread of the fungus.

It will be permissible in this relation to bring up an old question. Heroditus (III, 12), relates that upon the battle field of Pelusium, where Cambyses had besieged the Psammenites, the skulls of Egyptians and Persians lay intermingled. Those of the latter were so fragile that one could easily break them by a blow from a small pebble, while the Egyptians skulls could scarcely be broken by a blow from a large stone. This assertion is hard to criticize, as in the army of Psamminet there were numerous hired soldiers from Ionia and Karien. But it was particularly strange to him that upon the first large grave field which he saw in Egypt, that of Arsinoe (Crocodilopolis) in Fayum, the fragments of the skulls appeared as thick and hard as stone. This peculiarity is attributable to the thermal action of the sun. In many places in Upper Egypt, viz. : in Thebes, they have built in the small yards attached to the houses large structures of dried clay (Nile slum) which resemble large drinking cups, a solid trunk, with numerous branches supports above, a wide spreading shallow bowl with a high rim, like the bowl of a champagne glass. Into this the young children are placed while the parents work in the fields, and therein they stay with no protection from the glaring heat of the sun. He often saw children playing about on the red-hot manure fields of the Theban districts.

These children are plagued in a terrible manner by fleas. It is astonishing how these little insects adapt their habits to the circumstances of the climate. As soon as they perceive a human being they precipitate themselves upon a moist surface on the skin, and usually at the junction of skin and mucous membrane, which they seek and find with the greatest skillfulness, namely the eye, the nostrils, the lips, and especially the corners of the mouth. In the small children, who early are accustomed to the pests, fleas cover these places, and are with difficulty driven off. If this does occur they immediately alight in the same localities on any person who may be in the neighborhood. They naturally create a constant irritation, and also undoubtedly convey contagious diseases.

The dust in a storm is very bad, and in travelling by rail even worse. The fine dust of the dried Nile marshes covers everything with a brownish powder; the leaves of the books that one is reading, the food, and, of course, the skin and exposed surfaces of the mucous membranes. The modern part of Alexandria is regularly paved with flags, and the dust is not so troublesome there. But in the villages and in the other cities, Cairo not excepted, which still have unpaved streets, the dust seriously affects the eyes and respiratory organs. The desert sand is so coarse that in a storm its impact against the body is very perceptible.

The villagers—especially the field laborers—are accustomed to protect themselves from the sun's rays, the dry air and the dust, by abundant inunctions of oil. The women annoint their hair, which usually lies in little queues and braids, to such an extent that it drips with oil. To this the Nubian women add a coating of fine earth, until the mass resembles a stiff hood, and this is worn so for a month before being again barbered —a custom, as Virchow observes, which is well shown in the representations of the great wigs with which the ancient Egyptians were wont to adorn themselves.

The number of oil fruits which the Egyptians of old cultivated, and which to a great extent are still raised is very large. Amongst these, "Ricinus," from which the well known castor oil comes, is prominent. Herodotus (ii, 94) has already described its culture in detail. He calls the bush "Sillicorion," and goes on to narrate that the Egyptians cultivated it along the borders of the rivers or lakes, and used the oil as a salve. On the other hand, Wilkinson asserts that the Ricinus in some parts of the land is seldom grown. Virchow found it quite frequently, at times so large that it resembled a tree; especially in Nubia, where it grows in long rows by the river banks, and is quite noticeable from a distance. The odor of the natives is not improved by the use of this oil, but its action on the skin appears to be beneficial. It takes on quite a soft and tender feeling. He saw none of the diseases which are sometimes attributed to this inunction. The internal use of the oil appears to be utterly unknown to these people.

The food of the natives of Upper Egypt and Nubia is mainly vegetable. Meat is seldom eaten, and then only of chickens, turkeys, goats and sheep. Pigeons, though raised by the thousand for their dung, are forbidden as food. Horned cattle and buffalo are forbidden to some extent. Hen eggs and milk are also used as food. Potatoes are not cultivated. Fruit does not exist, as European fruit trees will not grow in Egypt. Oranges, lemons, pomegranates, figs, dates, and the fruit of the dwarf palm, and at times the chestnut, are cultivated. The chief nourishment of the people consists almost entirely of starchy food, part cereal, part leguminous. The women grind, stamp and powder the kernals of the "Durrha," or the maize, by grinding stones. Salt is obtained from the neighboring mountains where it is found abundantly in layers. It is dissolved and recrystallized at the houses. Many of the vegetables are eaten raw. Peas, beans, lupines and horse beans, are used. The beans are usually eaten either raw or slightly cooked. In Upper and Lower Egypt the sugar cane is largely bought and chewed in a raw state —it is credited with preserving and beautifying the teeth—and Virchow observes that for the most part the inhabitants possess beautiful teeth. The cane as a nutriment is useless, but in the heat it certainly acts as a refreshment.

The men, in spite of their simple food, and following the teachings of Mohammed, abstaining from all alcoholic drinks, are strong and capable of great exertion. They carry incredible weights upon the head and neck. They march the entire day in the blazing heat without long rests, and it is astonishing how the guides will run by the hour before a trotting horse, without losing breath.

Virchow was much impressed with the degraded condition of the women. Their work, apart from water carrying and meal grinding, is not very arduous. But their whole existence is an unhealthful one, and their appearance is, in most cases, anemia more or less pronounced. The faded, almost white appearance of the tongue, the gums and mucous membranes, in contrast to the dark skin of the countenance is really appalling. Chlorotic and nervous cases, indigestion and constipation, palpitation and weakness, almost to syncope are very frequent. This is produced not alone through the meagre diet, but also through the Mohammedan custom of confining and closely veiling the women. He saw Koptic women in their chambers who had *never* gone to the common meal, and who were even denied the privilege of the fresh air in the Royal Lustgarden just across the street. Again, squatting close to one another and deeply veiled, he saw one woman with diabetes and another with an ulcer of the stomach. The veil, or among the lower classes the dark mantle hinders the respiration; the outer covering of the body, the perspiration; the everlasting squatting and sitting with bent up legs, the circulation. It would, therefore, be surprising if any of these women live to an old age.

Medical art with all the mystical and magical surroundings united with it in the olden times, is in Egypt of extreme age. The second or third king of the first historical dynasty (some 4000 B. C.,) had a work on anatomy composed, and according to the writings of Lauth (Aus Ægyptiens Vorzeit) at different times there existed medical kings. Under the Ptolomies, that celebrated Alexandrian School flourished which, in spite of its short continuance, in the development of medicine, has exercised a lasting influence upon the anatomical foundations of our science. All this has, under the Arabs, gone to ruin, so that at present if the intelligent rulers wish to obtain the best instruction they must seek for help in Europe. French and English, Germans and Italians, at times working harmoniously, at others antagonistic, have sought to conduct their schools in this land, so that at present there is a confused mixture in Cairo of practical doctors and teachers. The German school is prominent through the works of such men as Pruner, Reil, Bilharz and Gresinger. The English hold the highest places in the sanitary service, civil and military.

The Arabian School of Medicine is making evident progress. The provincial doctors, at least those in civil places, are exclusively Arabian —some born in Egypt, some in Syria—and educated in the medical schools of Cairo and Beirut. Many of them speak no other language than Arabic. The united literature of cultured nations is closed to them. Virchow learned to know many of them, but did not find a single one who has enriched our art or knowledge. As is it is with the people, so, to all appearances, Egyptian medicine is becoming more and more Arabian. The new regulation for the medical school of Cairo, from November 19, 1887, decrees that all instruction shall be in the Arabian language. The entrance examination certainly requires an oral test, not only in Arabic, but also in French or English, and a written translation from the French or English into Arabic, and the reverse. But as all the professors cannot satisfy these requirements, great indulgence must certainly be exercised. The medical school is erected on good plans. A row of laboratories, for the most part spacious, gives good opportunity for practical exercise, and the museums, though as yet somewhat empty, add to the opportunities of the student. The botanical garden, under the care of Herr Sick, contains the more uncommon of the trees of the South, besides an abundance of medical plants. And finally, the spacious hospital, situated on the bank of the Nile, and at present under Dr. Milton's direction, offers an abundant and rich clinical field. Among the Arabian teachers is Osman Ghalib, prominent for his knowledge and popularity.

The next largest hospital is the Arabian hospital in Alexandria. Dr. Schiess, a Swiss, has full direction of this institution, and is also sanitary inspector of the city. He is taking great pains to develop and beautify the hospital. A new and larger pavilion was in course of construction. A large laboratory—at least for the present requirements—serves for the investigations of Dr. Kartulis, who was educated in Germany. The open site of the institution, beyond the city, quite near to the old harbor, and amidst gardens and trees, furnishes every hygienic requirement.

In Upper Egypt, in Assuit, he found an excellent civil hospital, under the care of Dr. Mahud Fahmy. In common with many other public hospitals, it is in the palace of a former prince, which now, for the first time, serves as a school. It has large, airy and cool wards, with more than sufficient administrative quarters. The patients and their beds looked neat and clean, and the results of the treatment in vogue seemed favorable. A small female ward was attached to this hospital. The hospital in Medinet el Fayum has rather a scarcity of patients. Three cases in all the spacious rooms was the total number under treatment. Besides the public civil hospitals, there are several small private hospitals which are supported by the voluntary contributions of strangers, and therefore attain no great degree of perfection. He mentions among this class the German Hospital in Cairo, which is under the care of Dr. Wildt. The building, though small, is erected on modern plans, and stands in an extremely well kept garden, amid rare plants and trees. The sick rooms, although of moderate size, and the out-patient department, are evidently constructed in accordance with modern ideas. The hospital enjoys, thanks to the untiring activity of both doctors and Sisters, general confidence. Owing to the short time at his command, he could not visit the Roman Catholic Hospital in Alexandria, under charge of Dr. Varenhorst. It stands in a well shaded garden.

The military hospitals were first called into existence through the English administration which followed the suppression of Arabi Pascha. At present every city which contains a garrison has also a military hospital. As the English troops are small in number, and occupy only the citadel at Cairo, there is only a special military hospital at that place. It is conducted in a practical manner in the former palace of Mehemet Ali. Its spacious rooms do not correspond to our medical ideas or tastes, but a residence here for the sick warriors who, far away from their fatherland, hope to regain their health, must appear to them as an honorable reward for the service they performed in a foreign land. The palace lies not far distant from the celebrated alabaster mosque, which rises to a great height upon the prominent rocks of the Mokhattem mountains. From the balcony one can enjoy an extensive view over the large city with all its suburbs and outlying villages; over the Nile valley, with its long chain of Pyramids; and again, in another direction, over a great part of the Delta. The refreshing north wind blows in all its purity over this balcony.

The wards are imposing in height and very capacious, communicating freely with one another and as a result the atmosphere is of remarkable purity. Here also Virchow found himself under the guidance of a countryman, the Head Steward, to whose good qualities the English staff bore the highest testimony, was born in Nuremberg, and had begged the special favor of conducting him.

The other garrison hospitals have been constructed through the untiring activity of Surgeon-General Rogers, to whom the scanty means of the Egyptian treasury could permit but small grants. Yet with limited financial aid he has accomplished wonders. Virchow saw the hospitals of Cairo, Wadi Halfa, and Elephantine, planned by Rogers. The others, as, for instance, that at Suakim, lay beyond the limits of his journey. Of these, he was most impressed with the barrack hospital on the island of Elephantine, which is newly erected and fulfils in an excellent degree the purpose of a climatic cure. Lying as it does on the southern boundary of Upper Egypt, it serves both as an intermediate station for the convalescents of Wadi Halfa and as a climatic resort for the troops of the northern garrisons, among whom are many negroes.

The hospital at Abbasiye is especially distinguished as the favorite of the Surgeon-General. It is situated in the desert, a distance of two miles northeast of Cairo, and was formerly a castle of the vice-regal family Outwardly there is seen no trace of vegetation, the air of the desert blows here in its pure state. Within its bounds, and surrounded by the buildings, which form a rectangle, is a large garden, where, under artificial irrigation, beautiful trees, shrubs and vegetables flourish. The long hall-like wards are cool and shady in the hottest days. The patients, here gathered from all the Egyptian army divisions, furnish samples of the ethnological types which are to be found in this wonderfully mixed army. The firm discipline which the English directory has enforced in the pure African regiments, ensures the observance of domestic order, although the natural waywardness at times breaks out. The course of diseases in Abbasyie is, according to Mr. Rogers, who personally conducted Virchow over the institution, exceptionally favorable.

Virchow describes the now world-famous bathing resort of Helwan or Heluan. The founder of the baths, Dr. Reil, owing to his influential post as body physician to the then Khedive, was enabled to happily surmount the many difficulties attendant upon the establishment of a place of this nature in the midst of a desert. The rich water of the Nile is not only carried onto a plateau at an elevation of thirty-five metres, upon which the hot sulphur springs break forth, but it is also deprived of the malarial influence of the marshes and pools which were formerly created by the imperfect drainage. At the hotel, with its various bathing facilities, there is a garden wonderfully beautiful in vegetation, while on either hand are villas. Close to the villas of the Khedive and his Court lie those of numerous rich residents of Cairo, who stay here a certain time each year; and again the more unpretentious houses which render the stay of the less wealthy invalids possible. This development of the place corresponds to its popularity. At the time of Virchow's visit (April 12th) the special season had closed, as the heat had driven the invalids northwards. They found only the doctor—Wickler by name—a native of Austria, and the tenant of the hotel, a north German, who prepared them an excellent breakfast. The baths were conducted on the European plan, and are well kept. The swimming basins for men and women, separately, were of sufficient depth and width for every kind of of exercise. All gave one the impression that the future of the baths was assured. To many sufferers here is the inestimable boon of the purest imaginable air. But they can not remove the fluctuations of temperature, and the expenses must always be considerable, as the whole existence of the place is artificial.

With the cessation of the present efforts the desert will again enforce its rights, as it has many times before succeeded in doing. A railroad connects Helwan with Cairo, which lies about five kilometres to the north. The trains are numerous and the service good.

## REVIEWS AND NOTICES.

WOOD'S MEDICAL AND SURGICAL MONOGRAPHS. Published monthly. Price, $10.00 a year; single copies, $1.00. New York: Wm. Wood & Co. Vol. I. No. 1.

This year the well known "Wood's Library" takes the form of a series of monographs selected from the literature of foreign countries. The January number is now before us, and contains the well known work by Jonathan Hutchinson, entitled "The Pedigree of Disease." This work consists of six lectures delivered at the Royal College of Surgeons, in the session of 1881, and refers to the manner in which temperament, idiosyncracy and diathesis influence the course of disease, and the susceptibility to different remedies. This subject is one of great interest and importance, as it touches upon matters that pertain to the every day experience of all medical practitioners. The other two articles contained in Vol. I are, "The Common Diseases of the Skin," by Dr. R. M. Simon, London, and "Varieties and Treatment of Bronchitis," by Dr. Ferrand. Both of these are instructive, and, at the same time, of sufficient brevity to admit of their being read without making too great a demand upon the limited time of the average physician or surgeon.

CLINICAL LECTURES ON CERTAIN DISEASES OF THE NERVOUS SYSTEM. By Prof. J. M. Charcot, Professor of the Faculty of Medicine, Paris; France. Translated by E. P. Hurd, M. D. Physician's Leisure Library. Detroit: Geo. S. Davis. Cloth, 50 cents; paper, 25 cents.

In this book, Prof. Charcot deals with various recondite subjects connected with neuropathology, which would tend to interest the specialist more than the practical physician. Hysteria, and especially hysteria in the male, is accorded more than usual consideration, and numerous extraordinary cases are cited illustrating this vague neurosis. According to this treatise, male hysteria belongs to every day medical practice, and the author hopes, by this publication, to more readily enable American physicians to recognize this disease. Unfortunately, this, like a few other neuroses, possesses no absolute semeiology, and it is to be sincerely hoped that hysteria will not be subjected to the same diagnostic abuse as has its equivocal prototype, neurasthenia.

DISEASES OF THE KIDNEYS. By Prof. Dujardin-Beaumetz, Member of the Academy of Medicine, and of the Counsel of Hygiene and Salubrity of the Seine, etc. Translated from the fifth French edition by E. P. Hurd, M. D. Physicians' Leisure Library. Detroit: Geo. S. Davis. Paper, 25 cents; cloth, 50 cents.

This represents another translated portion of the original "*Leçons de Clinique Therapeutique*," which has won such great popularity in France. This volume, devoted to diseases of the kidney, is deserving of the same just commendation, according to the other translated parts in previous reviews.

GONORRHEAL INFECTION IN WOMEN. By William Japp Sinclair, M. A., M. D. ON GIDDINESS. By Thomas Grainger Stewart, M. D. ALBUMINURIA IN BRIGHT'S DISEASE. By Dr. Pierre Jaenton. No. 2, Vol. I. Wood's Medical and Surgical Monographs, for 1889. Price, $1.00.

The startling assertions of Noeggerath, in regard to gonorrhea, were received by the profession with incredulity, and rightly so. But, as there is "a soul of truth in things erroneous," so is there in these extreme views a fundamental verity. Gonorrhea in women is a far more serious disease than it was formerly regarded. In its hateful train are cystitis, pyelitis, menorrhagia, pyosalpinx, acute and chronic ovaritis, perimetritis, peritonitis, sterility and other complications and sequelæ of various importance. These, Dr. Sinclair has described with the hand of the master, and, on some obscure point in etiology, many a gynecologist will receive from these pen pictures, a flood of light almost painful in its intensity. This monograph will assuredly promote the study of a neglected subject. Dr. Stewart considers giddiness as dependent on (*a*) external conditions; (*b*) changes in the sensory structures; (*c*) changes in the conducting fibres; (*d*) changes in the central nervous system; (*e*) dyspepsia; (*f*) toxic causes; (*g*) causes of uncertain seat; (*h*) peripheral irritation; (*i*) mental causes. He presents a valuable fund of information which will be found with difficulty elsewhere. The concluding monograph is of equal value and interest with the foregoing.

# MEDICAL NEWS.

## LICENTIATES OF THE BOARD OF EXAMINERS.

At a special meeting of the Board of Examiners, held Jan. 24, 1889, the following physicians were granted certificates to practise medicine and surgery in this State:

Amos Wilson Bickford, Pasadena; Coll. of Phys. and Surgs., Keokuk, Iowa, Feb. 14,'65.
Will S. Clark, Los Angeles; Central Coll. of Phys. and Surgs., Indiana, March 1,81.
William King Davis, Santa Rosa; Med. Dep. Univ. of Louisville, Ky., Feb. 28,'84.
Frederick A. Dunsmoor, Los Angeles; Bellevue Hosp. Med. Coll., N. Y., March 1,'75.
William A. Edwards, San Diego; Med. Dep. Univ. of Penn., March 15,'81.
Wm. Harry Early, Pennington; Coll. of Phys. and Surgs., Keokuk, Iowa, Feb. 14,'78.
Mack Jones, San Francisco; Kentucky School of Medicine, Ky., March 1,'77.
Johnson C. Lindsay, San Bernardino; Miami Med. Coll., Ohio, Feb. 29,'72.
M. A. Majors, Los Angeles; Mehany Med. Dep. Central Tennessee Coll., Feb. 25,'86.
Arthur Hugh Mays, San Francisco; Med. Dep. Univ. of Cal., Nov. 15,'87.
Isaac A. McCarthy, South Riverside; St. Louis C. of Phys. and Surgs., Mo., Feb. 28,'83.
Nathaniel H. McGirk, San Diego; St. Louis Med. Coll., Mo., March 2,'58.
J. A. McGuire. Santa Cruz; Starling Med. Coll., Ohio, Feb. 25,'81.
Charles J. Simmons, San Diego; Bellevue Hos. Med. Coll., N. Y., March 9,'85.
John C. Spencer, San Francisco; Coll. Phys. and Surgs., N. Y., May 12,'85.
Henry Gordon Tandy, San Diego; Col. Phys. and Surgs., Edinburgh, Scotland, May 11,'87.
Henry J. B. Wright, San Jose; Cincinnati Coll. of Medicine and Surgery, Ohio, June 22,'75; Jefferson Med. Coll. Penn., March 12,'81.

At a special meeting of the Board of Examiners, held Feb. 9, 1889, the following physicians were granted certificates to practise medicine and surgery in this State.

John Quincy Adams, Pasadena; Med. Dep. Univ, of the City of N. Y., Mch. 11,'53.
W. O. Anderson, Eureka; Coll. of Phys. and Surgs., Chicago, Ill., Feb. 28,'88.
Orren L. Barton, Truckee; Med. Coll. of Ohio, Feb. 28,'79.
John Bassian, Fresno; Chicago Med. Coll. (Med. Dep. Northwestern Univ.) Ill., March 12,'73. Imperial School of Med. of Ottoman Empire, Turkey, Sept. 7,'73.
Alfred D. Bedford, San Jose; Jefferson Med. Coll., Pa., March 10,'77.
Ezra S. Carr, Pasadena; Castleton Med. Coll., Vt., 1842.
Samuel R. Chamles, Los Angeles; Coll. of Phys. and Surgs., Keokuk, Iowa, Feb. 26,'84.
Alex. de Borra, Los Angeles; Univ. of Erlangen, Bavaria, Germany, June 21,'87.
Jos. W. Hunt, Los. Angeles; Med. Dep. Univ. of City of New York, March 4,'59,
J. W. Hupfeld, Los Angeles; Med. Dep. Univ. of City of New York, 1875.
Franz Kuchem, San Francisco; Univ. of Munich, Bavaria, Germany, Aug. 5,'81.
Amos J. Landis, Chico; Med. Coll. of Indiana (Butler Univ.) Feb. 27,'80.
Thos. R. Meux, Fresno; Med. Dep. Univ. of Pennsa. March 15,'60.
Francis F. Neff, Lathrop; Jefferson Med. Coll., Penn. April 5,'87.
Lewis P. Rossier, Sumner; Med. Dep. Univ. of Vermont, June 27,'78.
Samuel M. Slocum, Los Angeles; Med. Dep. Univ. of the City of N. Y. Feb. 18,'79.
Ernest A. Sturge, San Francisco; Med. Dep. Univ. of Pennsa. Mar. 15,'80.
Geo. Grainger Tandy, San Diego; Royal Coll. Phys. and Surgs. Edinburgh, Scotland, Nov. 12,'60.

CHAS. E. BLAKE, Secretary.

## Official List of Changes in the Stations and Duties of Officers serving in the Medical Department of the U. S. Army (Division of the Pacific), from to January 17th, 1889, to February 17th, 1889.

Leave of absence for one month, on surgeon's certificate of disability. is granted Major L. Y. Loring, surgeon. Par. 1, S. O. 6, Dept. of Ariz., Jan. 18, 1888.

Captain Henry S. Kilbourne, assistant surgeon, will accompany Battery E, 1st Artillery, changing station from Vancouver Barracks to Presidio, San Francisco, Cal., as medical officer, and, upon completion of this duty, will report to the commanding general Division of the Pacific for further orders. Par. 2, S. O. 6, Dept. of the Columbia, Jan. 22, 1889.

Captain Henry S. Kilbourne, assistant surgeon, having complied with Par. 2, S. O. 6, Dept. of the Columbia, will return to his station, Vancouver Barracks, W. T.. Par. 1, S. O. 9, Div. of the Pacific, Feb. 2, 1889.

The leave of absence, on surgeon's certificate of disability, granted Major Leonard Y. Loring, surgeon, in S. O. 6, Jan. 18, 1889, Dept. of Arizona, is extended six months, on account of disability. Par. 23, S. O. 35, A. G. O., Feb. 11, 1889.

## ITEMS.

**Sanitary Science in Political Economy.**—The importance of sanitary science in political economy is a fact that will ultimately obtain recognition. It is, therefore, a hopeful sign when we find that the work of the State Board of Health and its increasing usefulness has been recognized and acknowledged by the executive. We notice that the Governor of Tennessee has also recommended this subject to the consideration of the General Assembly, advising that a contingent fund be provided, and endorsing some measures of a similar nature to those which are now before the State Legislature.